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SETTING FISCAL PRIORITIES

TUESDAY, DECEMBER 9, 2014

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, McMorris Rodgers, Lance, Griffith, Bilirakis, Ellmers, Pallone, Engel, Schakowski, Green, Barrow, Castor, and Sarbanes.

Staff Present: Sean Bonyun, Communicatons Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Paul

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Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, O&I; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Minority Staff Assistant; Eddie Garcia, Minority Professional Staff Member; Kaycee Glavich, Minority GAO Detailee; and Karen Nelson, Minority Deputy Committee Staff Director for Health.

Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Despite some recent progress in reducing the deficit, the Federal Government faces enormous budgetary challenges. The Congressional Budget Office projects that the annual Federal budget deficit will once again approach the $1 trillion mark in a few short years. At the end of November, the Federal debt surpassed $18 trillion for the first time.

The consequences associated with the Federal Government spending and debt problem can't be overstated. In fact, former chairman of the joint chiefs of staff concluded that, quote, "The single biggest threat to our national security is our debt," end quote. Federal spending on healthcare programs is the major driver of the spending and debt challenge that America confronts.

Today's hearing is a critical step as the committee approaches the 114th Congress and considers proposals to tackle this the problem. Our biggest challenge is mandatory spending, particularly Medicare and Medicaid, which together accounted for 25 percent of all Federal spending in fiscal year 2013.

Medicare is on an unsustainable trajectory. In fiscal year 2014, it covered some 54 million people at a cost of approximately $618 billion. According to the 2014 Medicare trustees report, the program will become insolvent in 2030, in just 15 years. If Medicare spending accelerates in coming years, as many economists expect, then

Medicare's insolvency could come much sooner.

Medicaid expenditures are set to increase dramatically as a result of the Affordable Care Act's Medicaid expansion. Spending on the program is set to double over the next decade, even though it already comprises one in every four dollars in an average State budget.

These programs need to be strengthened and modernized, not just because millions of Americans depend on them for their healthcare, but also because out-of-control entitlement spending is crowding out other important priorities. For example, researchers, scientists, patient advocates, and many others have consistently told the committee that Congress should consider stabilizing and strengthening the National Institutes of Health as part of the 21st Century Cures Initiative. The NIH and other discretionary program priorities will continue to face budgetary challenges if entitlement program spending continues to take a larger and larger share of the budget.

The late Democratic Senator Paul Simon spoke to this larger issue when he said, quote, "A rising tide of red ink sinks all boats," closed quote. The Federal Government's mandatory spending on entitlement programs threatens Congress' responsibility to spend dollars on programs like the NIH. We need to consider solutions so that we can best target resources to these areas of priority.

Today's hearing is also timely in another respect. Next year Congress faces a number of important funding cliffs. In March,

Congress will need to confront the Medicare physician payment cliff and try to enact a permanent solution to the sustainable growth rate or SGR. In addition, the Affordable Care Act created a funding cliff for the States Children's Health Insurance Program. Funding for the program ends in September.

If Congress is going to tackle these problems and others facing the next Congress, we will need to come up with responsible ways to pay for these issues. Rather than turning to blunt tools like the Medicare sequester, we need policies that drive reform and savings that make sense. In addition, given that the Affordable Care Act has been the law for over 4 years, targeted reductions to the ACA must be on the table as we set fiscal priorities. I hope today serves as a catalyst to continue these important discussions about setting fiscal priorities.

I would like to welcome all of our witnesses on both panels today. I look forward to your testimony, to your recommendations on how to strength and save these critical programs. And I yield the balance -- I don't have much time.

I yield back the balance of my time and recognize the Ranking Member, Mr. Pallone, for 5 minutes for opening statement.

[The prepared statement of Mr. Pitts follows:]

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Mr. Pallone. Thank you, Chairman Pitts.

As a member of Congress, I believe that government can help all Americans succeed, including seniors and low-income populations and still continue to strengthen our economy.

While I agree we must do these things with fiscal responsibility, I do not agree that we need to balance the budget on the backs of our safety net programs. Improving and strengthening Medicare and Medicaid for generations to come is a primary goal of mine, but what Republicans want to do when they talk about setting fiscal priorities is to cut the structural foundation of these programs.

For the past 4 years, the Republican budget proposals have turned Medicare into a voucher program and turned Medicaid into block grants. But these changes do nothing to tackle healthcare costs; they simply undermine the program's guarantee of access to care and shift costs to beneficiaries, providers, and states. Shifting costs doesn't curb costs and doesn't shore up the long-term sustainability of our healthcare systems.

The Affordable Care Act began to make improvements to our healthcare system through delivery system reforms that improve both efficiency and quality. And I would argue that the Affordable Care Act was entitlement reform. It expands access to life-saving healthcare while also reducing Medicare spending. In fact, recent estimates show the increase in Medicare's per-patient costs are at

record lows.

In addition, the ACA laid the groundwork to reward value over volume, to incentivize providers to coordinate care and improve health. And that job needs to be finished, so we ought to be setting our priority to send our SGR repeal and replace the bill to the Floor before we adjourn for Christmas unpaid for, so that once and for all we can bring real sustainability and predictability to its providers and seniors.

The fact is that we are faced with an inevitable reality, our Nation's baby boomers are aging to the program at very high rates. In fact, 11,000 new seniors become eligible for Medicare every day. Meanwhile, the Medicaid program, as a result of the ACA, will allow millions of uninsured Americans, particularly the working class, to finally gain access to healthcare. But this doesn't mean we have a spending problem; it means we have a demographics problem. And to address that problem doesn't mean we need to slash the programs that American families need most.

Budgets, in my opinion, are about more than numbers and dollars. They are real-life expressions of priorities, of choices, and of values. These choices have an impact on the lives of millions of Americans, not just for the fiscal year each budget covers but for future years and future generations.

Now, I know that growing deficits are not good for the future but we can't reduce the deficit and give tax cuts to the wealthy on the

backs of our safety net programs. Instead, let's build on the ACA and continue to improve the value we get from our programs in a thoughtful and sensible way and find ways to take care of all Americans.

Now, Mr. Chairman, I would like to yield the time that remains to the gentleman from Texas, Mr. Green.

[The prepared statement of Mr. Pallone follows:]

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Mr. Green. Thank you, Mr. Chairman, and thank my ranking member for yielding.

We all share the goal of saving money and bringing down costs through making our healthcare system more efficient. Rewarding value over volume ensures patients have coverage and access to preventative primary care service and reducing uncompensated care should be part of this effort. As we explore key policy decisions facing Congress, cost shifting to the beneficiaries simply passes growing cost onto patients but does not address the true drivers of the growth in healthcare spending.

The Affordable Care Act included a number of numerous delivery system reforms that incentivize a more efficient healthcare delivery system. These activities hold significant promise for controlling spending while improving quality of care. When considering changes in Medicare benefits packages a strategy to bring down overall costs, it is important to recognize the difference between change that is designed for the benefit of the beneficiaries are those driven entirely by reducing Federal spending are those proposals which result in both?

I look forward to hearing from our witnesses this morning and exploring meaningful reforms that protect the most vulnerable populations and provide for the long-term stability of our healthcare system.

And again, I thank my colleague and yield back my 35 seconds.

Mr. Pitts. The gentleman's time is expired.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. Chair recognizes the Vice Chair of the Health Subcommittee, Dr. Burgess, 5 minutes for opening statement.

Dr. Burgess. Thank you, Mr. Chairman.

Fiscal year 2014, the government collected over $3 trillion in taxes for the first time, thanks to the generosity of the American taxpayer, and yet, we still had a deficit of almost .5 trillion. With our national debt reaching $18 trillion last month, we face the gravest financial situation in our history, and we must get serious about bringing that number down. If we don't start making difficult decisions now, our children, their children will inherit a burden unlike any generation previously has ever seen.

Under the best reporting, the Medicare Trustees project says that Medicare hospital insurance coverage is only solvent until 2030 and, in fact, it may be exhausted much sooner. Promises made to Medicare recipients exceed the payroll taxes to be collected from those receiving them by well over $100 trillion. Failure to repeal and replace the SGR has now cost over $170 billion over the last decade. Medicare part B itself surpasses $70 billion in 2012 alone.

This committee did do the right thing in repealing the SGR formula, and, yes, it got it through the Floor of the House. We were awaiting activity in the Senate, but as the clock ticks down on what remains in this Congress, it seems unlikely that the Senate is going to act. It is a lost opportunity. If we did the right thing and

enacted the bipartisan bill H.R. 4015, over the next decade, that would cost $144 billion, clearly less than the $170 billion that has been spent over the past decade.

Last year alone, Medicaid grew to an unprecedented almost $450 billion. With the State Children's Health Insurance Program, it is more of the same. The last five trustees reports have indicated that the Social Security's Old Age Survivors and Disability Insurance Program would be depleted by the third decade of this century. Time and again, the Government has promised more money than it has or could ever hope to take in.

And we haven't begun to delve into the discretionary side, but discretionary spending is $492 billion, and if all nondefense discretionary spending were eliminated, it still would not affect our debt. There are certainly investments that must be made, but it is imperative that we invest wisely.

For example, we spend only $500 million annually on Alzheimer's research, but well over $200 billion on care. The Alzheimer's Association reports that if we could delay the onset of Alzheimer's by 5 years, we would save approximately $170 billion in care costs by the year 2030.

Cancer, diabetes, asthma, each finds us in a situation in which we must decide how to prioritize our spending to help the people in a most fiscally responsible manner. We simply cannot ignore the

challenges or pretend that they will go away by themselves. It is a hard discussion, but it is one that we must be brave enough to start. That is what we were elected to do. That is what this subcommittee does, and that is what we are here to do today.

I certainly want to thank our witnesses for being here. I look forward to their testimony.

Mr. Chairman, I will yield back the time.

Mr. Pitts. The chairman thanks the gentleman.

[The prepared statement of Mr. Burgess follows:]

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Mr. Pitts. We have two panels of witnesses today. On our first panel, we have Dr. Mark Miller, Executive Director, Medicare Payment Advisory Commission. Thank you for coming today. You will be given 5 minutes for an opening statement. Your written testimony will be made part of the record.

The chair recognizes Dr. Miller for 5 minutes at this time.

**STATEMENT OF DR. MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION**

Mr. Miller. Chairman Pitts, Ranking Member Pallone, distinguished committee members, thank you for asking the Medicare Payment Advisory Commission to testify today.

As you know, MedPAC was created by the Congress to advise it on a range of Medicare issues. The commission's work is guided by three principles, to assure that the beneficiary has access to high-quality care, to protect taxpayer dollars, and to pay providers and plans in a way to accomplish these two goals.

The Federal Government is carrying a large debt. As the testimony points out, even though Medicare spending has slowed recently as a result of lower utilization and legislative restraint on payment increases, we need to continue to look at this program because the baby boom is transitioning into Medicare and higher per-beneficiary

spending is projected for the future. In the short run, the commission has many recommendations that would move Medicare away from a fragmented system that is unnecessarily expensive towards one that is more focused on coordinated care at a price the taxpayer and the beneficiary can afford.

Examples of short-run recommendations that would both restrain spending and remove financial incentives to focus on certain types of patients include eliminating the automatic updates for profitable fee-for-service provider sectors, like long-term care hospitals and inpatient rehab facilities, and actually reducing payment rates for skilled nursing facilities and home health agencies. It includes site-neutral payments that reduce the incentive to purchase physician practices and bill at the higher outpatient rates for the same services, recommendations that include site-neutral payments for similar patients that are seen in different post-acute care settings, and as you know, from our past research and recommendations, they have resulted in laws that are transitioning to a financially neutral payment between managed care plans and fee-for-service.

Our more recent research and recommendations, if accepted, would produce more competitively set payments for employer-based managed care plans. All of these policies were recommended after careful considerations on the effects of access to services and to plans. And of course, the commission continues to monitor the effects of these

policies and report back annually to the Congress.

Examples of short-run recommendations that would better align provider incentives to focus on patient care coordination and also to reduce unnecessary expenditures include an SGR reform plan that would end the annual cycle of short-term patches; a budget-neutral bonus payment for primary care providers and services that would allow physicians and other professionals greater flexibility to coordinate their care around the patient; and readmission penalties, some of which have been put into law, for hospitals, skilled nursing facilities, and home health agencies that would have the effect of discouraging expensive readmissions that disrupt the lives of patients and families.

Examples of short-run recommendations that would better align beneficiary incentives with the incentives outlined above include a major redesign of the traditional fee-for-service benefit where we recommended limiting total out-of-pocket expenses for beneficiaries, rationalizing the deductible, clarifying point-of-service cost-sharing liabilities, giving the secretary authority to alter cost sharing based on the value of a benefit, and imposing an additional charge on supplemental coverage policies to better reflect the cost they impose on the program and to send a clear price signal to the beneficiary. We have also recommended copayments for certain 60-day home health episodes and lowering copayments to as little as zero for low-income beneficiaries who use generic drugs.

In closing, we now have three payment models in Medicare, 30 million beneficiaries and traditional fee-for-service, 5 million are in accountable care organizations, and nearly 16 million are in managed care plans. Each has its own payment rules, risk adjustment and quality measurement criteria. Our most recent report begins a discussion of the future for the Medicare program that ideally would protect the patient by establishing common-risk adjustment and quality standards across these models, fairness among plans and providers within a market by setting common financial and quality standards, reduce the burden on plans and providers by reducing unnecessary quality reporting and reducing regulations for those who accept risk, and protecting the taxpayer by assuring that the program pays for low-cost, high-quality care in any given market.

I appreciate your attention to my comments, and I look forward to your questions.

Mr. Pitts. Chair thanks the gentleman.

[The prepared statement of Mr. Miller follows:]

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Mr. Pitts. And I will begin the questioning. Recognize myself 5 minutes for that purpose.

Dr. Miller, there have been five bipartisan plans to save Medicare introduced in this President's term. First, Rivlin-Dominici; second, Rivlin-Ryan; third, the Fiscal Commission; fourth, Simpson-Bowles' own plan; and five, plan by former Senator Joe Lieberman and Senator Tom Coburn.

The Lieberman-Coburn plan has been proposed in legislative text and was scored by the actuary of the Medicare program. The actuary said, page 6 of OACT analysis, that if this legislation was adopted, it would prevent Medicare's insolvency for decades and reduce senior's premiums so that they would be lower than under current law.

Please tell us what you think are the most actionable pieces of this proposal for this committee to consider adopting next Congress?

Mr. Miller. I am not going to be able to comment on this specific proposal. I am not that deep on it. But when you look across those proposals including the one that you named, there are elements of those proposals that also came out of recommendations or at least are consistent with recommendations that the commission has made.

If I remember correctly, and I really am not sure I do, there is a lot of these things and a lot of details, they were focused on some benefit redesign, including catastrophic caps, and I also think that they had something on altering supplemental coverage. The commission

has this additional charge. I think they took a different approach where they said supplemental coverage wouldn't be able to cover the first few dollars of coverage in order to assure that the beneficiary had some price signal on a service that they consumed. And those are consistent directions even if they are different mechanisms for achieving the same thing.

I also think that there was some elements in some of those plans to reduce the home health payments, and that is certainly something that came out of our work. Off the top of my head, that is a couple of things.

Mr. Pitts. I want to ask about Medicare benefit redesign proposals. Some of my colleagues on the other side of the aisle have examined MedPAC's recommendation on creating a combined deductible for parts A and B, a catastrophic limit on out-of-pocket spending, and Medigap reforms that would limit first dollar coverage. The minority is on record in their hearing memo claiming that many patients might see higher cost under these proposal plans.

I think the minority might be overlooking the savings that accrue to a beneficiary over time as a separate 2011 analysis concluded four out of five beneficiaries could save money if such a proposal were adopted.

Could you please discuss the effect that such reforms would have on beneficiaries especially over multiple years and can you comment

about whether or not a beneficiary who would otherwise face higher costs could enroll in a Medicare Advantage plan?

Mr. Miller. Okay. I think you have a few questions in there.

The first thing that I would say is benefit redesign, when you think about a catastrophic cap and adjusting the deductible, there is several ways that it can affect the beneficiary. But one thing to keep in mind is, is that what you are doing, and it is almost inescapable is, is you are shifting the liability across the distribution of beneficiaries.

Generally, what you are doing with these things when you go for a catastrophic cap is there is a small set of beneficiaries with very high liability that you help and other beneficiaries who have less healthcare costs have more healthy experiences probably pay more for a deductible. So there is some redistribution.

But the other objective that you are up to here is by setting a catastrophic cap, and, for example, in our recommendation, making copayments as opposed to coinsurance, which is less predictable, the beneficiary has clear a line of sight on what their out-of-pocket liability would be. This would mean that the beneficiary's need to buy a supplemental policy should be less. That is the idea.

And to the extent that beneficiaries say, "I no longer need a supplemental policy," then that is an out-of-pocket expense that they no longer incur and that is a place where they could potentially achieve

savings to the beneficiary. So there is some moving around of liability and there is some potential savings, depending on whether the beneficiary continues to carry a supplemental premium.

You asked another question about the impact on the beneficiary. In the short term, it does mean that certain beneficiaries would incur greater liability because they might have a higher deductible, for example. But over time, those beneficiaries run a greater risk, because of their age and just the natural progression of disease, run a greater risk of going into the hospital or hitting the catastrophic cap. And we have done some analysis which we can send to this committee where we show that the percentage of people affected, helped by this, for example, grows from 9 percent in the first year to 30 percent when you go out -- or 19 percent when you go out 5 years, 30 percent when you go out 10 years.

So over time, more beneficiaries are likely to benefit from a catastrophic cap or a reconfigured deductible depending on their health experience, which they run greater risk over time.

Mr. Pitts. Chair thanks the gentleman -- go ahead.

Are you finished?

Mr. Miller. I am done. No, go ahead. Sorry.

Mr. Pitts. I thank the gentleman.

And recognize the Ranking Member, Mr. Pallone, 5 minutes for questions.

Mr. Pallone. Thank you.

Dr. Miller, in MedPAC's June 2012 report and in your testimony for today's hearing, you note that the proposal for Medicare benefit redesign reduces risk and increases predictability for beneficiaries by adding an out-of-pocket catastrophic cap and a lower combined deductible together with predictable copayments for services. The proposal also recommends a fee on supplemental insurance plans such as Medigap and retiree plans. And as you can imagine, I have heard some concern about this idea.

Your rationale appears to be because first dollar coverage can encourage inappropriate use of care that Medicare should recover some of the increased program costs that result from this excess use of services. Now, while I agree that an out-of-pocket catastrophic cap would be an improvement, I have concerns about the impact of your proposal on Medigap or supplemental insurance policies, and particularly concerned that these will be viewed as separate and unrelated proposals.

Can you clarify then, are these different policy options, or are the two components of this proposal actually linked to one another?

Mr. Miller. The commission was really clear on this, I believe, that this was a package of proposals; that you do the benefit redesign, as you outlined there, along with the additional charge on the supplemental coverage.

Mr. Pallone. Okay. Now, I understand your proposal retains current protections for low-income seniors related to cost-sharing and premiums. And one of my concerns is that I believe the current low-income protections are inadequate. I am concerned that taxing or otherwise discouraging these first dollar coverage supplemental plans would negatively impact the near poor who do not currently qualify for assistance under Medicaid. So could you just comment on that?

Mr. Miller. Yeah. The commission did talk about this quite a bit. There is collective concern that if that is your concern, the Medigap product is not a particularly effective way to get at that. Often, the premiums and the benefits that you get from it just result in dollar churning, if you will, sort of dollar trading, and some of the premiums can be quite high.

What the commission said is if that was a concern, and we made a specific recommendation on this point, would be to alter the Medicare savings programs and go more directly at providing subsidy to the poor and near poor. And specifically what we said is change the income qualification to be consistent with the income qualification for part D (LIS) and raise it to 150 percent of poverty, and then have a premium subsidy for the QI population, which starts to get into some complexity, but for this answer, you have a premium subsidy for the QI beneficiaries.

Then what they do, they are relieved of, let's just call it $1,300

in part B premium, which they can then use to pay for their out-of-pocket copayments and deductibles and that type of thing. And within the package, we would see that as being financed out of the savings that come out of the Medigap portion of the proposal.

Mr. Pallone. Okay. I know we use the term "near poor," but I wish we had a better term than "near poor." It seems so strange.

Let me ask another question. In MedPAC's proposal for redesigning Medicare's benefit package, the commission is clear that two overriding objectives are to give beneficiaries better, more predictable protection against out-of-pocket spending, and to create incentives for them to make better decisions regarding discretionary care.

But many of us would agree there is a need to simplify the structure of Medicare benefits in ways that make it more understandable and user friendly for beneficiaries and provide them with better protections by providing out-of-pocket spending caps, like private insurance plans.

So my question is: Unfortunately, the notion of creating incentives for beneficiaries to make better decisions is often looked at only through the narrow lens of increased cost sharing. Can you talk about ways other than cost sharing that benefits can be structured to encourage use of appropriate high-value services and discourage the use of unnecessary services? In 40 seconds or less.

Mr. Miller. If I follow it, I think there is two comments: One is, the portion of the recommendation that spoke to the secretary's authority to adjust cost sharing on the basis of value, I would just point out, just in case you missed it, that toggle would go both ways. So if a benefit is high value, you could actually lower the cost sharing or zero out cost sharing for your diabetes visit or whatever the case may be.

Mr. Pallone. Right.

Mr. Miller. So the toggle doesn't entirely increase cost sharing and could be lower cost sharing, just in case that got by you.

The other thing, I mean, then I think you move to different kinds of ideas. For example, a while back, we made recommendations for prior authorization for very expensive imaging services. I mean, I think then either you have to move in that direction in fee-for-service or move in the direction of a beneficiary being in an accountable care organization or a managed care plan where those kinds of tools are more readily available to manage the beneficiaries experience.

Mr. Pallone. All right. Thank you.

Mr. Pitts. Chair now recognizes Vice Chair of the Subcommittee, Dr. Burgess, 5 minutes for questions.

Dr. Burgess. Thank you, Mr. Chairman. Before I begin, let me ask unanimous consent to submit written testimony for today's hearing by the Coalition to Preserve Rehabilitation for the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Dr. Burgess. And again, Dr. Miller, thank you so much for being here and sharing your expertise with us. Let's talk for a minute about the trend of hospital acquisitions, hospital acquiring practices and the consolidation that really seems to have increased dramatically in the past couple of years.

In one of your earlier reports, you discuss the trends of hospital acquisitions costing Medicare more and driving up costs. The report discusses in great detail how this is happening in cardiology. This past May, I asked if the commission had seen this trend in other specialties, specifically oncology. Do you have any additional information that you can share with the subcommittee to add on this or to build on this?

Mr. Miller. I probably can't do it very well off the top of my head here, but there is some additional information that we could give to you. We took a look at other requests at kind of the trends in radiation therapy and in chemotherapy, and you do see some trends there that are consistent with the things that we have presented previously.

And I would also remind you, and I know this is a detail that would not be readily apparent, in the recommendation that we made on our site-neutral payments, which encompassed about 66-some-odd conditions where we said you should set payment rates equal to or near what is paid in the physician's office, a few of those conditions actually overlap the oncology, you know, drug administration codes and that type

of thing.

Keep in mind, in oncology, you have sort of two things happening. The drugs are actually paid comparably. It is really the administration and what goes on around the drugs that are not paid comparably, and our recommendations would affect that. But in any case, we have some of that contemplated in our recommendation, and there is some additional information that I could forward to you or your staff on a particular issue.

Dr. Burgess. Great. That would be good. Do you recall overall if that trend is a trend upward in the cost curve, or is it a flattening of the cost curve?

Mr. Miller. Yeah, and I am going to do this off the top of my head -- which is really a dangerous thing -- what I recall from the work that we did is if you look at radiation therapy, it is a lot more oblique. But if you look at chemotherapy, there does seem to be a shift from the office setting to the hospital setting. That is my take away there.

Dr. Burgess. Well, and, again, it would be very helpful if you could provide that information to us.

Mr. Miller. Uh-huh.

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[The information follows:]

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Dr. Burgess. If there were more parity in reimbursement rates between the outpatients and acute care settings, for example, raising reimbursements in certain settings, lowering it in other settings, how do you think that would affect consolidation?

Mr. Miller. If there was greater parity, is that what you were saying?

Dr. Burgess. Parity. Yeah.

Mr. Miller. Well, we think it would have some dampening of the trend. Am I getting the question?

Dr. Burgess. Yeah. And I think, overall how would that affect the cost in the Medicare programs? Do you think that would be a reduction in cost?

Mr. Miller. Absolutely. I mean, we have made two recommendations, for example, to equalize the payment rates between visits in the physician office setting in the hospital outpatient setting, and then, as I said, develop this criteria and identify these 66 other services that we would set the rates. And for example, on those two, at about 1 billion plus a year, that would reduce spending of which, you know, just in round numbers, 20 percent of that would be a reduction in the beneficiary's cost sharing, which is something I would just bring us all back to.

I mean, particularly when these services just shift and are billed through the outpatient setting, it is important to keep in mind here,

we are not talking about people actually leaving the office and going to the outpatient setting in most instances. They are still going to their physician's office. They are still getting the same service. The payment from the program has gone up and the beneficiary's cost sharing has gone up, and to the tune of about 1 billion, 1.5 billion per year, if these two recommendations were put into place.

Dr. Burgess. Has the committee looked at what happens to patient access costs with hospital acquisitions of specialties?

Mr. Miller. You could be asking me one of two questions. We have --

Dr. Burgess. Well, when a hospital takes over what traditionally has been like a cardiology practice, what are the benefits of the cost of the patient when you move this site of service?

Mr. Miller. What are the benefits?

Dr. Burgess. Yeah, and what are the costs, well, for the beneficiary? I meant, that is after all where the focus should be.

Mr. Miller. Yeah, our concern is that the benefit to the beneficiary is pretty static, that they are getting the same service. Like I said, in many instances they will walk into the same office, see the same physician, and just pay a higher out-of-pocket.

If there were hospitals sitting here, they would argue that they do this in order to create systems of care and have greater degrees of coordination. We have not seen access problems, and we have not

seen a lot of evidence to back up the claim that this results in better coordination or better outcomes for the beneficiary.

Dr. Burgess. Mr. Chairman, I see my time is expired. I have an additional question on graduate medical education that I would submit for the record. Thank you.

Mr. Miller. Thank you.

[The information follows:]

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Mr. Pitts. Chair thanks the gentleman.

And now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Dr. Miller, recent estimates from the Medicare Trustees highlight continued success in reducing spending under the Medicare program. Medicare spending per beneficiaries projected increase by just 0.3 percent in 2014, well below the growth in GDP. Is it correct that Medicare costs have grown at a consistently slower rate than the private sector and total healthcare spending growth has reached the lowest rates since 1960?

Mr. Miller. I can't stipulate each of those facts. What I would say is this: There has been a general slowdown in utilization in both the private and in the Medicare sector, so both of those have actually seen slowdowns in spending. I would guess that you are right that Medicare, depending on whether we are talking about growth rates, may be slower than the private sector because commercial insurers still have higher price growth than Medicare had, so just distinguishing between use and price. But there has been a broad-based slowdown in spending on both the private and the Medicare side in terms of utilization in the last few years.

Mr. Green. Okay. Thank you.

The Centers for Medicare and Medicaid Services recently reported

that from 2012 to 2013 hospital readmissions in Medicare were decreased by nearly 10 percent with the help of Medicare's Hospital Readmission Reduction Program, translating to 150,000 fewer hospital readmissions. Congress took further action by enacting readmissions reduction program for nursing homes under the Protecting Access to Medicare Act of 2014, which established a skilled nursing facility value-based purchasing program based on readmission reductions in the fiscal year 2019.

Mr. Miller, what changes to current Medicare reduction programs might you recommend the further increased care coordination and cost reduction?

Mr. Miller. Okay. There are a couple things I think I would say in response to this. You know, ideally what you don't want to do, unless you have to, is impose penalties for these kinds of behaviors or, you know, abhorrent behaviors, high readmission rate. But when you have a fragmented fee-for-service sector you are sort of driven in that direction.

And so what the commission's view kind of works like this: We have recommended a readmissions penalty for hospitals, which has been implemented; as you said, skilled nursing facilities is coming on line; we also have a standing recommendation on home health readmission rates. The view there is, at least the major actors involved in a readmission would have an incentive to avoid it. They have an

incentive to talk to each other and stop this kind of stuff from happening. Nobody benefits from this. Extra payments, beneficiary's families.

Now, ideally, where we would be moving to is think of bundled payments or an ACO or a managed care plan where that actually becomes their incentive, because if they can reduce a provider or plan, if they can reduce the readmission, then that actually turns into revenue for them.

Mr. Green. Yeah.

Mr. Miller. The other thing I would just say about the penalty, and I won't get into the weeds here, we want the penalties -- and we have some specific ideas on this -- structured in such a way that people avoid the readmission. In a sense, we don't want the penalty; we want them to avoid the readmission, which is a much more, you know, better event for everybody. And we have some recommendations to change the readmission penalties as they stand to get at that outcome a little more.

Mr. Green. Okay. Well, and that is the concern, you know. I know the penalty, and the penalty doesn't help anybody, but the goal is to move that behavior so they actually treat that person fully.

Mr. Miller. We think there is -- well, go ahead. It is your time.

Mr. Green. And I don't have a lot of time left, but I know over

the years we have also had some concerns about infection rates from being in the hospital and there has been efforts to do that. Can you compare in a short time now the readmission rate issue with the penalties compared to what we have tried to do on the broader scale in infection rates at some of our hospital facilities?

Mr. Miller. Actually, I think I am going to have to come up short here. I am much more familiar with what is going on with the readmission rates. I am aware of the hospital-acquired conditions, measures. I can't give you a good answer on what effects and what observable effects there are. I am just not up to speed on it.

Mr. Green. Again, appreciate you being here and thank you.

Mr. Miller. I apologize.

Mr. Green. Chairman, I yield back my time.

Mr. Pitts. Chair thanks the gentleman.

And now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman.

Dr. Miller, welcome. I like this discussion on this readmission thing because my understanding is the penalty kicks in even if the readmission has no relation to the original hospitalization; is that correct?

Mr. Miller. Well --

Mr. Shimkus. There is a penalty. So, you know, someone is in

there for an internal procedure but then they leave and then something else happens, they break their leg, they go in, they are readmitted. There is no discrimination over the cause and effect of why you are penalizing them; is that correct?

Mr. Miller. Yeah, and I am just going to -- I am going to parse through this a little bit. You are decidedly correct that people complain that there is not enough definition in the readmission criteria that parses things like a planned readmission or a readmission that is really related to the initial admission.

But I will say two things: First of all, the commission's position is it should be all condition, risk adjusted, potentially preventable, and that is the code word for get the planned ones out of there, and there is probably some clinical judgment that applies to situations like you are saying.

But the key point that I want to get across to you, just in case it is not clear: The penalty doesn't litigate on the basis of readmission by readmission. It looks at the overall rates of the hospital and says, if you are way to the right in the tail, that is where the penalty applies. So even if there is some disconnect, it is not case by case. I would just get that point across to you.

Mr. Shimkus. So maybe percentage-wise, based upon the overall admission, readmission rates that deal with that.

Mr. Miller. Exactly.

Mr. Shimkus. I think that is helpful. I would be adverse not to use Sydne in one of her last days -- although she's not paying attention to me -- in her ability to put charts up.

And I want to have her put up one, because your role is, you know, the Medicare Payment Advisory Committee, and I bring this up all the time just to make sure we highlight the challenges that we face budgetarily and also the importance of your role.

Because even when I go to my two questions, it would be, I would say, nibbling around the edges versus really actuarially trying to make a system whole and the red being mandatory spending that has to go on regardless of what we do. The blue is discretionary. That is what we fight about all the time.

Sydne, you can take that down. I wanted to harass her one last time.

But to my question is, we asked last time you all came on the 340B program and what affect it has on the Medicare program. Can you comment on any ideas that you might have to realize savings in Medicare as it relates to the 340B program?

Mr. Miller. Yeah, we took that statement and statements that other members said on the same point very seriously. And the commission, if I remember correctly, things are running together a little bit, I believe at our November meeting had an extensive discussion about the 340B program, its growth, what the various

conflicting incentives were, what, you know, one, the drug manufactures were arguing, what the hospitals were arguing, all of that, because we were asked to kind of paint the picture for the committees.

I just need to quickly say, by and large, all of this program is beyond our jurisdiction. It is not Medicare and it is not administered by CMS, but since the committee has asked, we wanted to lay the picture out and now we will give that to you and you guys will do what you do.

However, there was one thing in it, and we have only noted it for the commissioners at this point. We haven't actually taken action on it, and I think this is what you are getting at. In the outpatient setting, Medicare pays what is called the average sales price plus 6 percent, and that is what Medicare reimburses and there is a whole bunch of details about how that gets calculated. But if the hospital realizes a discount on the 340B then there is some difference between what the hospital acquired that drug at and what Medicare is paying at, and Medicare does not follow that.

And that is as far as we have gotten. We have put that in front of the commission, but I have not much more to say about it than that.

Mr. Shimkus. Great. And let me finish up, the President on the part D and Low-Income Subsidy Program, the President's proposal would encourage seniors to increase generic drug use when a viable alternative to a brand name is available. Has the commission taken a position on the low-income subsidy reform, since this policy, we

think, could save, obviously, money for both the program and the seniors?

Mr. Miller. Yeah. I don't remember where the President's budget proposal came, whether it was before or after ours. I think it was after. But we made a recommendation a while back on this front, and our point was that even low income -- and this is tricky, but even low-income beneficiaries are price sensitive. And if you say, for example, and give the plans the flexibility to say you can zero out the premium for a generic drug, and keep in mind, this policy would only be in situations where there is a generic substitute, then the beneficiary may gravitate more to that.

Because what we found in the data is, is that you have less generic use in the low-income subsidy population. And I had always had this perception, well, this is because they use extremely expensive specialized drugs, and decidedly, some of them do. But a lot of their profile is the standard drugs for which there are generic substitutes, and so we thought that this would help get some push there.

Mr. Shimkus. Thank the chairman.

Mr. Pitts. Chair thanks the gentleman.

And now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Thank you, Mr. Chairman.

Thank you, Dr. Miller for being here. It is nice to focus on

something substantive and especially where some good news in Medicare that we have seen a slowing in growth of health spending, the fifth consecutive year of slower growth. And CMS says this is the slowest growth since 1960, so we need to put that to work in extending the life of the Medicare Trust Fund.

And more good news, the Affordable Care Act reforms are working. We have talked a lot about hospital readmissions and that is quantifiable already. And then we have a lot of reforms dealing with the accountable care organizations and focused on quality over quantity where the jury is still out but it looks promising.

But we still have now this challenge with the baby boomers beginning to retire and they are going to call on Medicare. They are looking forward to coming onto Medicare. It remains very popular. So we have a very important responsibility to ensure Medicare remains strong. I think the past attempts to look for quick solutions like turning it into a voucher, we really need to move away from that divisive dialogue because that is not going to solve anything. It simply shifts costs to beneficiaries that can't afford it.

So the hard work is going to be getting into the details. What is fraudulent? What will help bring greater efficiency? What can we do to bring developments in modern diagnosis medicine treatments to bare to extend the life of the trust fund and provide care?

I want to ask you a variation on what Representative Green was

talking about in hospital readmissions but focus on post-acute care settings. Under the current Medicare payment systems there are no financial incentives for hospitals to refer patients to the most efficient or effective setting so that patients receive the most optimal but lowest cost care. Whether a patient goes to a home health agency or skilled nursing facility, for example, seems to depend more on the availability of the post-acute care settings in a local market. The patient and family preferences or financial relationships between providers.

So since patients access post-acute care after a stay in the hospital, what does MedPAC say we should be doing to ensure patients receive care in the right setting after a hospital stay?

Mr. Miller. I think there is a few things, and I will try and build the answer this way: First of all, in the arriving settings, like a skilled nursing facility or in home health, we think that there are underlying incentives built into the payment system now that encourage taking some patients and avoiding others. So we think, at a very bumper sticker level, what you want to do is take the physical rehab patients. You want to avoid the medically-complex patients. We think that there is some very straightforward analytical adjustments or technical adjustments to the payment system that start to remove those incentives so you get something more of a clinically-driven referral instead of a financial referral.

I won't run through all it again, but the notion of having a readmission penalty among the actors of saying you need to do this carefully and get them to the right location. Otherwise, if they come back to the hospital everybody has some impact, then we think that would help.

Ms. Castor. Okay.

Mr. Miller. There are also -- well, just let me get these two things out quickly. We have also made a whole set of recommendations on accountable care organizations that we any would make those more viable and workable, and within those we think the incentives of all the actors are aligned.

And then the very last thing I will say -- I am sorry -- is we just had a conversation, I think it was in November, in which the commissioner started to ask themselves, even within fee-for-service should we give hospitals greater flexibility to steer patients on the basis of higher-quality facilities?

Now, that is not a recommendation but that is a discussion that is in progress. Sorry to take your time.

Ms. Castor. Okay. No, I was interested in your answer.

On Medicare part D, Medicare part D spending now is well over $60 billion per year and over 10 percent of all Medicare spending. Is MedPAC satisfied right now that the competition among plans -- 1,100 prescription drug plans, 1,600 Medicare Advantage PDPs, great choices

for consumers -- is MedPAC satisfied that the competition among plans is providing strong enough incentives for cost saving?

Mr. Miller. Well, it is interesting you ask that question. We are just about to start talking about that in some greater detail. What we have been noticing over the last few years in part D is that the most rapid growth in the program is our reinsurance portion of the benefit. And so that is raising questions in our mind about whether there is some re-examination of the structure to relook at whether there is a greater degree of competition that could be injected into that program.

I don't have ideas for you right at the moment, but in the back room, those are churning in order to come out in front of the commissioners shortly.

Ms. Castor. Good. We will look forward to those.

Thank you.

Mr. Pitts. Chair thanks the gentlelady.

And now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you.

Welcome, here Dr. Miller. Good to have you.

I want to talk a little about some of the cost-shifting issues. Basically, I am assuming when we are talking about cost shifting, if a person may be seen in primary care, but if they cannot get the

specialty care they need, that person may face other complications from their illness. Would you agree?

Mr. Miller. Yeah.

Mr. Murphy. Okay. And I saw a recent report that said those persons who sometimes have the greatest problems with readmission are people with low-income families. Would you agree with that?

Mr. Miller. There is a relationship between readmission rates and income, yes.

Mr. Murphy. And is that, some of that relation may also be that sometimes people have maybe compliance issues, or perhaps they don't have access to some of the things they need, some of the specialists and medications, et cetera?

Mr. Miller. I would have a hard time telling you precisely what the mechanisms are. I think there is a relationship there. It might be the things that you are saying. I think there are a lot of things that are said. I think the exact pathways that lead to it are less --

Mr. Murphy. Let me describe one. I read research reports that say that senior citizens with Medicare with chronic illness, have double the rate of depression and some mental illness. And that when it is untreated depression and chronic illness, that doubles the cost. So access is important to make sure that, under those circumstances, a person, for example, with heart disease or cancer or diabetes, has an increased risk for depression; and, therefore, treating that is an

important cost-savings factor.

So therefore, if that is not treated, that is a cost shifting, that instead of providing the psychiatric or psychological care that cost will be borne by further complications with diabetes, cancer, heart disease, pulmonary disease. Does that make sense?

Mr. Miller. I see that.

Mr. Murphy. Now, one of the issues I have been deeply concerned about is of access to inpatient psychiatric care for the severely mentally ill. As you may know, Medicare has a 190-day limit on inpatient psychiatric care. But we don't impose this for heart disease, do we, or lung disease or diabetes or cancer? Do we have 190-day limit for those?

Mr. Miller. There is not a 190-day limit for that.

Mr. Murphy. So wouldn't you agree that this is discriminatory?

Mr. Miller. I agree it should be looked at. The facts said I am a little bit hazy on, but as you have presented it, I see your point.

Mr. Murphy. But with 190 days, though, I mean psychiatric diseases are brain diseases, but should we have a limit on diseases in terms of the number of days you can be treated for that?

Mr. Miller. The only thing I would like to do is have the room to come back to you on this and make sure I understand what the implications are of agreeing to that is.

Mr. Murphy. I am not sure what implications you are looking for.

Mr. Miller. Well, a couple things. There may be limitations on other parts of the benefit that I don't have right at the front of my mind, and I wouldn't want to agree for the commission to say yes without being able to tell you what the cost implication of that would be.

Mr. Murphy. I understand. Well, and if there are limits, we certainly would like to know that, because the issue becomes one of what is the proper level of care.

Mr. Miller. Exactly. And that is all I am looking for is some latitude on.

Mr. Murphy. And if there is 190-day limit for psychiatric care but that is not enough to treat someone.

Mr. Miller. I hear you and I see the direction of your question. I would just like some latitude to actually think about it and come back to you.

Mr. Murphy. Can you also then, when you are looking at that, find out how many seniors are affected by this cap? So when looking at the number of seniors, we need to know the costs of that.

Mr. Miller. That is what I want to make sure I don't mislead you on and say, yeah, no problem and then, you know, come back with --

Mr. Murphy. And I appreciate your thoughtful approach, to this, because we need those kind of facts. When we ignore the mental health needs of seniors with chronic illness and that leads to other costs, we are not saving anybody anything. We multiply those costs.

And so sometimes when there is a resistance within Medicare to change a rule, well, we can't afford more than 190 days, but we will end up doubling the costs of oncology or cardiology or something else. It just doesn't make sense to us. So I hope you will give us a comprehensive look at that issue.

Mr. Miller. Absolutely. And, you know, I don't want you to take the response as hostile to the ideas. I just don't want to commit the commission to saying, sure, go above 190 days without giving you more complete thought, because we are the kind of people who would look at that and come back to you and say, if you are going to do that, there may be some other things that you want to do to make it more episode-based type of approach to the beneficiary's experience.

For example, if the person leaves the inpatient psychiatric facility, is there actually a set of ambulatory visits arranged for that person when they walk out the door? Because I think our experience is, that is where things begin to break down.

Mr. Murphy. Good to see it, and monitoring and integrating that care. Same thing goes with pharmacology when you see that the mass amounts of medications that people don't follow through on leads to readmission or more complications, et cetera. It is a huge cost.

Thank you so much. We look forward to hearing from you.

[The information follows:]

**This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.**

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Mr. Miller. I would like to just think about it more holistically. No hostility to the thought.

Mr. Murphy. No, I appreciate that. Thank you.

I yield back. Thank you.

Mr. Pitts. Chair thanks the gentleman.

Now recognizes the gentlelady from Illinois 5 minutes for questions.

RPTS KERR

DCMN HOFSTAD

[11:30 a.m.]

Ms. Schakowsky. Thank you, Mr. Chairman.

Thank you, Dr. Miller.

I just want to put in context some of the things we are talking about. The average Medicare beneficiary lives on an income of -- half of all Medicare beneficiaries -- $23,500 or less, and a quarter of them live on $14,400 or less.

We are talking about how we strengthen Medicare for now and for the future and costs. And we have done a lot, I want to point that out, to actually reduce the costs of Medicare.

The Centers for Medicare and Medicaid Services, CMS, recently reported that the Medicare Shared Savings Program and the Pioneer Accountability Care Organizations, ACOs, that were created by Obamacare have generated about half a billion dollars in savings for the Medicare program.

A recent report by the Agency for Healthcare Research and Quality found that we saved approximately $12 billion in healthcare costs as a result of reductions in hospital-acquired conditions from 2010 and 2013. $10.7 billion in fraud-fighting tools under Obamacare. That is over $23 billion.

But the important thing to me is that it hasn't done anything to reduce the benefits of the people who need it the most. And so I just want to make sure that we have policy solutions that save Medicare money but don't harm beneficiaries.

And there is a recent report that I would like to put into the record. Medicare Rights Center/Social Security Works released a report, "A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs."

Four strategies, including restoring the Medicare prescription drug rebates, allowing Medicare to negotiate drug prices for Part D public option, and a solution -- and let's see -- securing better discounts for drug manufacturers to close the donut hole, promoting cost-effective prescribing for Part B prescription drugs.

And I would like to --

Mr. Pitts. Without objection, so ordered.

Ms. Schakowsky. Thank you.

[The information follows:]

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Ms. Schakowsky. So here is my question, though. I am very concerned that this idea of making sure seniors have and people with disabilities have more skin in the game, that we -- the CMS Medigap tool shows that in Evanston, my district, Evanston, Illinois, the average cost of a Medigap plan for someone in good health is between $129 and $318 a month for a Medigap C Plan and $118 to $262 per month for a Medigap F Plan, both of which include deductibles.

But CMS still estimates that, even with these plans offering first-dollar coverage, a senior or person with disability would still spend over $6,000 on health care each year out of pocket.

So why should we ask these Medicare beneficiaries to pay more, eliminating first-dollar Medigap coverage?

Mr. Miller. Well -- and this goes back to the conversation on the benefit design. And I want to be clear. I mean, the Commission --

Ms. Schakowsky. Dr. Miller, could you pull your microphone closer?

Mr. Miller. Oh, sorry about that. So nobody has heard anything I have said for the hearing?

Ms. Schakowsky. No, it is just me. Just me.

Mr. Miller. So, let's see, where were we? Benefit redesign.

The Commission shares your concern. And, particularly, you had a statement in your -- "We should do reform, but we shouldn't harm beneficiaries." Okay? There was a lot of discussion about this.

Now, one more time, just to go through this, the benefit redesign works like this: It has a catastrophic cap. So that beneficiary you are talking about now has an additional protection, and particularly the person you are talking about who starts running into $6,000, $7,000, $10,000, that is what a catastrophic cap is all about: Stop, you know, the amount of out-of-pocket headed out the door.

The second thing we would do is have copayments instead of coinsurance. So, you know -- and you have had this experience -- you pay 20 percent of a bill that you don't know what it is going to be. It is hard to plan for, as opposed to I walk into the physician's office, I pay 20 bucks, or I walk into a specialist's office, I pay 30 bucks; I know what I am going to pay. The thought process in all of this is that the beneficiary has more protection and clearer line of sight.

And to be really clear on this, the Commission's principle was that the beneficiary's liability, as it currently stands, doesn't change under this benefit redesign. So we are not putting more liability on the beneficiary. There is a distributional change, meaning the sick get more coverage. But there is no aggregate change in the liability.

Then we say, if you want to buy that coverage, the coverage would come with a higher price, which reflects the cost that it imposes on the program. But, ideally, you don't need it the way you used to need it because the benefit is better and we expanded the Medicare Savings

Program up to 150 percent of poverty to capture that group of people between 135 and 150 who would potentially have a out-of-pocket problem.

Ms. Schakowsky. I am going to put some further follow-up in writing.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. Schakowsky. Thank you.

Mr. Pitts. All right. The chair thanks the gentlelady.

I now recognize the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions.

Dr. Gingrey. Mr. Chairman, thank you.

Before I ask my questions of Dr. Miller, I want to ask unanimous consent. In 2012, Dr. Roe, myself, Dr. Barrasso, and Dr. Coburn submitted a report titled "What Happens To Payments to Health Care Providers Participating in Medicare When the Medicare Hospital Insurance Trust Fund Reaches Exhaustion?" Since this is apropos to the discussion, I would like unanimous consent to have that approved for the record.

Mr. Pitts. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Dr. Gingrey. I want to go back, Dr. Miller, to the line of questioning that Ms. Schakowsky just had, because I think this is hugely important and I want to make sure that I understand it fully. It is somewhat controversial, but it seems like the facts maybe speak for themselves.

You said approximately one in six Medicare beneficiaries had an individually purchased Medicare supplemental insurance policy in recent years, known as Medigap, and no other source of supplemental coverage.

The Kaiser Family Foundation released a report evaluating a proposal that would prohibit Medigap policies from paying the first $550 of enrollees' cost-sharing and requiring that they cover no more than half of Medicare's additional required cost-sharing up to a fixed out-of-pocket limit.

The Kaiser Foundation revealed some notable findings, and let me point those out, three bullet points. If this policy were adopted, four out of five seniors would save money from Medigap reform, and most of those that could face higher cost would instead choose a Medicare Advantage plan. The second bullet point: With this reform, some seniors would save more than $1,000 from Medigap reform. And, thirdly, this policy would also create savings, which would strengthen Medicare.

Given the obvious upside of the policy, why hasn't Congress adopted this policy sooner? And what are the given obstacles to

adopting this commonsense policy?

Mr. Miller. Oh. So the question is why, as opposed to the policy.

Dr. Gingrey. It is, indeed.

Mr. Miller. I would rather talk to you about the policy, but I guess, just to be very direct, what I would say is that, obviously, the people who sell the Medigap plans would oppose such a policy. And I think one way you could think about trying to navigate this -- and just to be clear, this is all your turf -- is, you know, there are two ways to think about Medigap reform.

What has been said in the Kaiser study says only products can be sold that don't have first-dollar coverage. So the beneficiary has to pay something in order to get the service. And this is what the Congresswoman was referring to. The other way you could do it -- and this is what the Commission said -- is you can buy any product you want, first-dollar or not first-dollar, but the charge on it has to reflect the true cost of the policy. Because the policy imposes the cost on the program, and that is not reflected in the premium.

And I think reasonable people could take either of these approaches, say, okay, I am going to say the product has to have this structure, or put an additional charge on it. But the folks who sell Medigap policies are not going to like either of those.

On the beneficiary -- I mean, I think the other resistance that

you get to this -- and it is raised by the beneficiary groups -- is what about those people who -- and I guess the term is "near poor," at least in this area that we are talking about, where they are not poor enough to be covered by Medicaid but they don't have enough resources to pay their out-of-pocket. And there, I think what the Commission would say is maybe you fill in the Medicare Savings Program up to 150 percent to try and help that crew out.

But I think your resistance is from the Medigap industry, and then I think the beneficiary groups are concerned about that bloc of people who are left without a supplemental.

And one more time, I am just going to say this. Ideally, if the benefit redesign has a catastrophic cap and clearer cost-sharing, the beneficiary's need for this should also be reduced.

Dr. Gingrey. Yeah. And, Dr. Miller, I would think that is the most important point, the catastrophic cap.

Mr. Miller. Yeah, because we are talking -- I mean, the reason that the Kaiser -- I don't have all those facts in my head, but the reason Kaiser said this is a savings to the beneficiary is, I mean, these premiums are, you know, $1,300, $1,400 for these products.

Dr. Gingrey. Right. And many people don't need that. They will never reach that catastrophic cap, and it is really unnecessary.

So, Mr. Chairman, I will yield back 28 seconds. Thank you very much.

Thank you, Dr. Miller.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman.

You said that the policy impacts the cost of the program. Just give me a couple examples.

Mr. Miller. The policy?

Mr. Sarbanes. The policy with the Medigap, like that the nature of the policy has an impact on the cost to the --

Mr. Miller. Oh, okay.

Mr. Sarbanes. -- Medicare program.

Mr. Miller. We think the research -- if I follow your question, and if not, redirect. We think the research on this is very clear. What happens when you look at the presence of the supplemental coverage, after you adjust for the risk of the patient, you find a lot more discretionary services. So there are more visits, more imaging, more testing, that type of thing. It doesn't affect hospital, emergency room services.

Mr. Sarbanes. Right.

Mr. Miller. That goes on about its business. But these policies, because there is no further --

Mr. Sarbanes. But ups utilization that spills over onto the

Medicare --

Mr. Miller. And then that is not reflected --

Mr. Sarbanes. -- coverage side.

Mr. Miller. And what I have tried to say, and perhaps not clearly, is that doesn't get reflected in the premium.

Mr. Sarbanes. Right.

Mr. Miller. The person purchasing the product gets this package which is priced to just the wrap-around benefit, but there is a cost over here that travels on to the taxpayer and to the beneficiary's broader premium.

Mr. Sarbanes. Right. Well, it is obviously very complex, and --

Mr. Miller. Yeah, it is.

Mr. Sarbanes. -- it is gratifying that you are approaching it as much based on the reams of data that Medicare has at its fingertips as you possibly can.

I am glad that this discussion, wherever people may come down on it -- and, you know, you have the Medigap plans with their perspective, insurers on one side and beneficiaries potentially on the other side, and maybe there is some common ground that can be achieved. But at least the whole discussion is happening within the context of maintaining the basic tenets of the Medicare program, which is that it is guaranteed coverage of one kind or another.

So, in that sense, it is in strong contrast to some of the

proposals that we have seen in recent years -- for example, the proposal to turn Medicare into a voucher program, which completely upends the basic principles upon which the program is operated for all of these decades and is really at the heart of it.

So we will kind of continue to find our way on what the best sort of outcome is for this discussion, but I am glad it is being done in a kind of fact-based environment and one that doesn't abandon in any way the basic operating principles of the program.

I was curious -- and you may have a document like this, but if not, would it be possible to produce for us a document that just kind of takes a Medicare beneficiary who purchases a Medigap plan and says, you know, here is the before picture of how they are managing that situation and here is the after picture under these two or three scenarios in terms of the reform to give us a better sense of, in practical terms, what that looks like from the beneficiary's standpoint?

And maybe what you do is you choose, if there are certain categories of beneficiaries that assemble around one kind of an option currently, take that category, show us the before scenario and show us the after scenario, take the next category and show us the before and the after, just so we can get a sense.

I mean, for example, not all beneficiaries purchase these Medigap plans, as you made very clear, so I don't know if the before and after

picture is pertinent to that group or not, but it may be. But certainly for the folks that do, if they fall into some distinct categories that allow for comparison, that would be useful.

Because when we are talking to our constituents and trying to translate this potential policy change to them as beneficiaries, that would be the most useful way to capture the data and the proposal for us. So I don't know if there is something like that, but if it is possible to produce something like that, I think it could be useful.

Mr. Miller. Yeah, there are certainly, in the reports, averages that do that type of thing, but I think your request is a little bit different. You know, could you make it a little bit more directly relevant to the beneficiary, a beneficiary who looks like this --

Mr. Sarbanes. You know, and is paying X a month, and when that X a month represents, kind of, on average what a whole category of beneficiaries are paying, you know, this is what would happen under this proposal. That would be helpful.

Mr. Miller. There might be an illustrative example or two that we could put together that would bring this point home for you. It would be very hard to represent, you know, the full breadth of a beneficiary's experience.

Mr. Sarbanes. I understand.

Mr. Miller. It is going to necessarily be incomplete.

Mr. Sarbanes. Right.

Mr. Miller. But there might be a couple of illustrative examples that we could put together for you.

Mr. Sarbanes. Thank you.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. Lance. Thank you, Mr. Chairman.

Dr. Miller, there is a growing concern over the high cost of dual-eligible beneficiaries, eligible for both Medicare and Medicaid. As you know better than most, there are two separate funding streams. Different payment rates and coverage rules often create conflicting financial incentives that result in higher costs and poor coordination efforts.

In 2010, the President's fiscal commission recommended giving Medicaid full responsibility for providing health coverage to dual-eligible persons and requiring those persons to be enrolled in Medicaid managed care programs. Would you please comment on the merits of this policy, both pros and cons?

Mr. Miller. I am not going to be able to. The Commission has not taken that up, per se, and, you know, I am here to represent their view, so there is not a lot I can bring to bear on it.

There have been discussions around things like the dual-eligibles' demonstrations and some of the issues there, and there

have been some discussions around those. These kinds of conversations always kind of have a continuum to them, which are, do you take this population and put it in the hands of the State, and then you have to start asking questions about how the Federal dollar follows in that instance? Versus the other approach, which other people have argued, which is -- and this is, in a sense, what -- not in a sense -- directly what happened in Part D, where you say, okay, the beneficiary now becomes a Federal responsibility, and then the dollars from the State travel in that direction in order to support this.

The Commission has not broadly, for the dual-eligibles population, talked about, in that continuum, you know, the solution that should be considered. So I can't really give you much there.

Mr. Lance. Given the aging of baby boomers and climbing rates of obesity and obesity-related disease, do you expect that the cost pressures created by dual-eligibles will continue to increase?

Mr. Miller. Yeah, I think that this is an expensive population and a population that really, you know, is most susceptible to the problems that arise from not coordinating among the clinicians and actually not coordinating more broad social types of services around these particular beneficiaries.

Although I do want to say quickly, we talk about -- and I do it, too -- duals as kind of a monolithic group of people, and they are very different -- cognitive disabilities, physical disabilities. There is

a significant range of people within the dual-eligible population.

But that said, I think this is a population where there is need for people to be focused on more care coordination activities, both around their clinical needs and around their social needs. Otherwise, I think the price does go north.

Mr. Lance. Given the fact that there are different types of people in dual-eligibles, should we differentiate between the different type of person who is in the dual-eligible category?

Mr. Miller. That is a really fair question, and honestly -- and, again, this is a comment that is probably not so much the Commission -- my own thinking has gone back and forth.

Sometimes I have had this view that you have to really think about designing programs around specific populations within the dual population. And then, at other times, I have sort of felt like, well, maybe you can think about coordinated care plans but allow benefit flexibility within the plan, for example.

And then there is a whole set of questions that, if the beneficiary stays out in the fee-for-service environment, how you actually build the coordination around that particular environment, which I think continues to be complicated even if you are not dual-eligible.

So I have to tell you, my own thinking has moved around on this, and on any given day I am not sure what answer I would give you on this.

But there has to be, I do think, some more -- I think I would say

this -- some more tailored approach. Because, you know, a cognitive disability is not a physical disability, is not -- you know, there are different populations. And so there has to be some flexibility to put the right kinds of providers and services around a given population. There probably does need to be some flexibility there.

Mr. Lance. Thank you very much.

Mr. Chairman, I yield back 10 seconds.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. Engel. Thank you very much, Mr. Chairman. Thank you for holding today's hearing.

I believe the reforms included in the Affordable Care Act have improved Medicare's long-term fiscal situation and protected beneficiaries' access to guaranteed benefits. And just last week, the Centers for Medicare and Medicaid Services reported that health costs grew just at 3.6 percent in 2013, which is the smallest increase since 1960, and the reforms included in the ACA resulted in the Medicare Trust Fund remaining solvent till 2030, which is 13 years longer than the projected date prior to the passage of the ACA.

With regard to protecting beneficiaries, HHS announced last week that, from 2010 to 2013, there were 1.3 million fewer hospital-acquired conditions, resulting in 50,000 lives saved and $12 billion in

healthcare costs avoided. The ACA pushed healthcare providers to improve patient safety by providing Medicare payment incentives to improve the quality of care provided and launching the HHS Partnership for Patients initiative.

Medicaid is a lifeline for many of my constituents. I am pleased so many States, including my home State of New York, have taken this opportunity to expand their Medicaid programs and care for the most vulnerable citizens. However, certain Governors have used the excuse of the uncertain Federal funding for Medicaid as a reason not to expend their programs. I think that is wrong and shortsighted.

Looking only at the dollar figures and associated healthcare spending with regard to the ACA, Medicare, and Medicaid fails to adequately convey the tremendous importance these programs have to the basic wellbeing and health of millions of vulnerable Americans, young and old. Their value in this respect cannot be understated and should be our primary focus as we look at the long-term fiscal situations surrounding these programs.

Let me ask you, Dr. Miller -- let me say this. MedPAC made GME recommendations a few years ago that many people have used to push for Medicare -- GME, graduate medical education -- cuts. With one in six physicians trained in my home State of New York, I have concerns that cutting Medicare support for GME or physician training would make it very difficult for teaching hospitals and medical schools to carry out

their missions. Additionally, these proposals would change the long-established shared investment between medical schools, residency training programs, and the Federal Government to financially support doctor training.

So let me ask you this. By 2025, the Nation will face a shortage of more than 130,000 physicians, split evenly between primary and specialty care. Medical schools from across the country have done their part to address the shortage by increasing enrollment sizes, and teaching hospitals are training residents above their cap. Medicare GME cuts could financially exhaust the ability of teaching hospitals to train additional resident physicians.

With this said, does MedPAC support the notion of cutting Medicare GME funding?

Mr. Miller. What MedPAC said -- MedPAC, in 2010 I think, made a broad recommendation to reform the GME approach in Medicare, and it has the following characteristics.

So the analysis that we did suggested that the curriculums that were current in residency programs were not really focused on team-based care, decision support instruments, that type of thing, getting training outside of the hospital, getting training in rural areas, that type of thing. So we made a recommendation that there needed to be new criteria to have reorganized residency programs. And then we took a little more than half of the indirect medical education

funding and said, these dollars should be devoted to entities -- and it wouldn't just be hospitals -- who are providing this more reformed approach to graduate medical education.

So to try and answer your question directly, we didn't take the dollars out of the system, but we said that the dollars should be allocated differently than they are now. A hospital can be a recipient of it if they are a part of these reformed programs, but they are not necessarily the only entity for which these dollars would be available.

Mr. Engel. Okay.

Let me quickly switch, and just let me give you a general question. Can you elaborate on what you believe are the most promising efforts under way to encourage providers to deliver high-quality, high-value care?

Because, in your written testimony, you stated that the Commission remains focused on pursuing reforms that control spending and create incentives for beneficiaries to seek and providers to deliver high-value healthcare services.

So what do you believe are the most prominent, promising efforts under way to encourage providers to deliver this kind of high-quality, high-value care?

Mr. Miller. Well, I mean, it is kind of the whole array of things that I mentioned here. So, you know, there are things in the fee-for-service world like readmission penalties and reformulating the

way we pay for skilled nursing facility and home health services. We have made recommendations on accountable care organizations to make them more viable options. We have made recommendations that Congress has adopted on the way we make payments in managed care, and we think that that industry is moving in a much more efficient direction.

There is a very long list here with time out here that -- but it is in the testimony. The testimony is basically, from first to the last page, a list to answer your question.

Mr. Engel. All right. Thank you.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this very important, very informative hearing.

And, Dr. Miller, I appreciate your testimony.

My first question: Dr. Miller, one of the great things about the Medicare Part D program design is that it harnesses the forces of choice and competition to reduce costs while improving the options for seniors. Premiums in the program have been basically flat over the last few years, and seniors truly love the program.

I noticed that MedPAC has examined and endorsed a competitively determined Medicare planning bidding system for the future of the

Medicare program. Can you talk about the merits of this approach and how it is similar to or different than the Medicare Part D or Medicare Advantage?

And then could you also explain, to what extent would it free Congress from annually having to adopt price controls to pass Medicare's fee-for-service system?

Mr. Miller. Okay.

The first thing I just need to clear up, we did not endorse it. We did publish a chapter and sort of discuss the issues. And what we were trying to do is kind of strike a balance in the policy conversation.

You could take an approach broadly in Medicare like you take in D, where you say there will be a competitively set government contribution, and then the beneficiary would select a plan, and the plan is either a managed care plan or fee-for-service, even though that is not a plan, and then pay the difference, depending on how expensive it is. So that is the thought, I believe, you are chasing here.

And what we said is that that is a legitimate conversation that should occur, but there is a set of design issues that become extremely important here in how well this is done and how successful it is.

One right off the top that I think a lot of people miss is, in the private sector, there has been tremendous provider consolidation over the last decades. Your questions about the site-neutral payments are all about that kind of phenomenon. And to the extent that there

has been greater consolidation, commercial insurers have had a really hard time holding down payment rates because you have a very consolidated provider in certain markets.

So approaching these competitive models, you have to be very conscious of how you are going to extract reduced prices from these providers who in the private sector actually have consolidated positions. In Medicare, you have administered prices, so you don't deal with that.

Now, the technical, you know, questions about how you deal with that are probably beyond a 5-minute answer, but the first thing to keep in mind is, if these things aren't done right, they can actually cost Medicare money. But there are technical issues to navigate around that.

A couple of other issues are things like this: Do you standardize the benefit, which would say it is very clear to the beneficiary, be very clear to the Congress what they are paying for and what works and what doesn't work, or do you allow complete innovation in the benefit design, or something in between? The MA plans, you have to provide certain services, you have ability to play with the cost-sharing. And so you have to think about that.

Another big issue that you have to think about if you go down these roads is where you set the government contribution. If you do it at a national level, then there are certain parts of the country where

everybody pays, fee-for-service or managed care, and other parts of the country where everybody gets a premium rebate, for lack of a better word, whether you are in managed care or fee-for-service. If you do it within the market, that is probably a more rational way to go at it, but there is probably then some subsidization that is occurring across the country, and you will have to deal with the implications there.

So what we tried to -- oh, and then -- I hate that this came off as an afterthought -- what are we going to do with the low-income? So if there is a premium support here, then how are the low-income going to be handled?

So what we did in this report is just blocked through a set of issues and said, if we are going to have a serious conversation about this, there have to be answers to each one of these issues. And we kind of went through the pros and cons, and we did a little simulation, very static, not high science, but a little simulation of some of the distributional impacts. And I would refer, if you want to have this conversation, refer you to that.

Mr. Bilirakis. Very good. Thank you very much.

In November of 2012, CBO issued a paper on the offsetting effects of the prescription drug use on Medicare spending. Basically, proper adherence to a prescription drug regimen in Medicare Part D would provide a savings from hospitalization in Medicare Part A.

Can you talk a little about this spillover effect and savings? Also, do you think that eliminating duplicative medications and proper monitoring of dangerous drug interactions could also add to savings in the Medicare program?

Mr. Miller. I mean, we decidedly have been -- we had some discussion of this on opioids just recently -- decidedly concerned about overmedication and, you know, drug-to-drug interaction and that type of thing. And you want to deal with that not just for savings reasons or even whether it saves or not; you want to focus on that because of the impact on the beneficiary.

Our research is in a little different place than CBO's. We have seen that, we have talked to them, we went through it. I believe they have done it very carefully, and there is a lot to commend it.

Our own research has somewhat more ambiguous results. We see this effect where you get the savings on the hospital side, you know, your better drug compliance reduction and hospital effect. But the hospital effect kind of goes away after 6 months, a year. And we are a bit confused by that, and we are still kind of churning on it ourselves.

You know, great if compliance -- I mean, you should probably have compliance for medical and clinical and all the rest of the reasons anyway. If it has a savings effect, great. We are having a little trouble, you know, coming to the same conclusion.

Mr. Bilirakis. All right. Thank you.

I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. Ellmers. Thank you, Mr. Chairman.

And thank you, Dr. Miller, for being with us today.

I want to go back to some of the discussion of the site-neutrality payments. And I, again, just for the purpose of my questions, want to again clarify, has MedPAC taken a position on whether or not Congress should act on the issue of site-neutral payment reform?

Mr. Miller. Yeah, we have made two recommendations as it relates to E&M visits and then -- I won't take you through all the weeds, but --

Mrs. Ellmers. Uh-huh.

Mr. Miller. -- the 66 conditions that we carefully identified so that it didn't undercut the hospital's mission and didn't create access issues for the beneficiary and said those should be --

Mrs. Ellmers. What is the number-one reason that we should address this policy change and reform?

Mr. Miller. I mean, I would say -- you know, I have 17 commissioners, so I don't know, but my number-one reason is that the beneficiary is out-of-pocket. If they are getting the same service --

Mrs. Ellmers. Yeah, the increased cost.

Mr. Miller. Right.

Mrs. Ellmers. Okay. I just want to -- there again, I do want to clarify that. That is what we are seeing, and it seems to be a discussion and a question of, you know, if you are receiving the same care at a facility which is an ambulatory outpatient, you know, minus the hospital, why then is the hospital charging more, I guess I would say, for the consumer.

So, now, getting back to that issue, too, back in June of 2013, the report that came out from MedPAC discussed the cost differences, especially in cardiology. And I think the question was posed at that time, have you seen this in other specialties? And for my purposes today, I am thinking about oncology. Have you also seen this cost increase in oncology?

Mr. Miller. Right. And you made a specific request in our last hearing, and we delivered to your office a response on this very question. And this is what I was dragging up from my memory to Mr. Burgess' questions.

Mrs. Ellmers. Uh-huh.

Mr. Miller. We looked at oncology. We looked at radiation -- divided it between radiation therapy and chemotherapy. Kind of oblique results on the radiation therapy side. On the chemotherapy side, it does look like there is an uptick --

Mrs. Ellmers. Increase.

Mr. Miller. -- in the outpatient, which is really the billing --

Mrs. Ellmers. Yeah.

Mr. Miller. -- and, you know, some shift between the physician's office and the outpatient.

Mrs. Ellmers. Okay. Yes. Thank you. Because I am kind of coming off of what Dr. Burgess was asking you about.

I do have another question, which is kind of off my line of questioning here, but I do want to make sure that I address it. It goes in line with what my friend Congressman Shimkus was talking about, some of the issues regarding readmission -- I believe it was Mr. Shimkus -- the readmission within 30 days and the loss of payment if there is a readmission.

And he addressed the issue of it being possibly a different diagnosis but still receiving that loss of reimbursement. I believe you said it has more to do with the number of readmissions that that particular hospital is having.

But my understanding -- and this is what I want to clarify with you -- is that it can also be a readmission to a different hospital. And if it is a readmission to the different hospital, how does that process work?

And I am very concerned about this, because my understanding is that we are going to go to an increase in the number of diagnoses of readmissions.

So can you clarify or shed some light on how that process works? Does the initial hospital end up getting the ding if there is a readmission to another hospital within 30 days?

Mr. Miller. Yes. That is correct.

Mrs. Ellmers. Okay. So there that is. Okay. Great.

Next question. And this has to do with North Carolina and Medicare Advantage. I am very concerned. Medicare Advantage facing $200 billion worth of cuts through the ACA. North Carolina, 57,000 Medicare Advantage recipients are being told that their plans will not be offered in 2015.

You know, Kaiser Family Foundation has found this to be true and that other States are not facing the number of cuts to some of these plans.

Can you shed any light on that or any of your -- I mean, how can my constituents deal with that, when they like their Medicare Advantage plan so much?

Mr. Miller. Well, I can't speak to North Carolina specifically in that particular set of plans. We have documented this extensively and will do again next month at our -- or, actually, next week at our public meeting.

We have continued to see 9 percent annual growth in managed care enrollment. We have seen more organizations entering. And the average numbers of plans being offered, I think, is still 9 or 10, on

average, in any given market. And, of course, some markets, like Miami, have 30, and other markets have 5, but --

Mrs. Ellmers. Uh-huh.

Mr. Miller. -- you know, we have seen continued growth in enrollment in this program.

Why those specific plans feel that they have to pull out -- and the dilemma for you and your colleagues in the Congress is you want the beneficiary to have access to the plan and have the extra benefits, but I think -- and you have to decide this for yourself -- you want those extra benefits to be provided because the plan is efficient relative to fee-for-service and has the extra money because they are good at what they do. If you just give them the extra benefit, then you are right back to --

Mrs. Ellmers. Right.

Mr. Miller. -- your debt situation.

Mrs. Ellmers. Well, thank you, Dr. Miller.

And thank you, Mr. Chairman. I have gone over a little bit, so I apologize. Thank you.

Mr. Pitts. That is all right. The chair thanks the gentlelady.

Now recognize the gentlelady from Tennessee, Ms. Blackburn, 5 minutes for questions.

Mrs. Blackburn. Thank you so much, Mr. Chairman.

And, Dr. Miller, I want to say right with Mrs. Ellmers' thoughts

on Medicare. You just talked about the 9 percent growth in enrollment in a lot of the programs. And one of the things I hear from my seniors is they are beginning to realize that, with the arrival of Obamacare, that you had about $700 billion of cuts that were made to Medicare, to the trust fund, and that that money is now being used for new government programs that aren't for seniors.

And they are figuring this out because they are asking the questions, why is my plan being terminated, or I don't have as many options, or my copay is higher. And they are looking at this, and they have figured out that that redirection has taken place.

And, of course, they are looking at the pay-fors, and that was the across-the-board annual reductions in the growth rates of Medicare payments for hospitals. And these cuts are scheduled to continue every year permanently. And, as a result, the actuary of the Medicare program has said, basically, you have a couple of choices here; you have up to 15 percent of the hospitals could close and many hospitals could stop taking Medicare patients, or Congress can reverse the cuts and increase the rate of Medicare spending, accelerating the insolvency of the program.

So, in your view, would it be better to scrap the reductions and replace them with other policies? What would be your advice there?

Because you have constituents like Ms. Ellmers who are saying, well, we are beginning to catch the brunt of this, and then you have

the hospitals, where they are facing these reductions and they are saying, well, we don't know how we are going to keep our doors open. And I will tell you, quite frankly, I have a lot of rural hospitals that deal with underserved areas.

So what is your thought there? What is the better plan?

Mr. Miller. Okay. Well, I will leave it to the Congress to decide which plan --

Mrs. Blackburn. Well, we would just like your insight.

Mr. Miller. No, I will give you a couple.

Mrs. Blackburn. Good.

Mr. Miller. But, remember, our role here is just to put a set of ideas in front of you and then let the Congress decide what is the right thing.

Mrs. Blackburn. Well, and we appreciate that.

Mr. Miller. Right. And --

Mrs. Blackburn. That is what we are looking for, are those thoughts and ideas.

Mr. Miller. Yeah. And I will say two things in response to your question, because there were two things in there, I think, and maybe more, but at least two, that I teased out.

One is, on the managed care plans, regardless of whether Obamacare or whatever the health reforms to the side, the Commission looked at the managed care plans -- and this is the exchange I just had here -- and

said, look, before 2010, every time we enrolled somebody in managed care, it cost the trust fund money. Managed care plans were actually bidding to provide the basic Part A and Part B benefit at a more cost than fee-for-service. These are the managed care plans who said fee-for-service is broken and we can do better, and they were actually delivering it for greater cost.

So whether there is Obamacare or whatever, the Commission's recommendation was that payment system was broken. And what we were trying to drive it to -- and we believe this has happened now -- managed care plans that are actually efficient, get the efficiencies, then offer the extra benefits. And we are several years down the road. Enrollment continues to increase, and plans are actually, on average -- or some plans -- bidding below fee-for-service, proving that they can be more efficient than fee-for-service. I want to emphasize "some plans."

So we think, our view on that, that had nothing to do with any health reform. You know, that is a different world. We were saying that about managed care.

On the fee-for-service side, where you are seeing the cuts and the concerns about hospitals, what I would say to you is we come to you, by law, you know, the law that you created for us to respond to, every year and tell you what we think is the best thing that you should do for hospitals, physicians, skilled nursing facilities, you name it.

And what we do is we look at the current law -- and we are not bound by current law in our recommendations. So we have said things to take payment reductions below what is in PPACA, the Accountable Care Act, in some instances, and in other instances we have said, no, they are too low, you need to go up.

So we actually come in -- and there was a statement made by the chairman, you know, we need policies that kind of think through the circumstances. And that is what we try and provide to you on an annual basis, is come to you and say, stay with the law here, go below the law here, go above the law here. And that is what we do every year in our March report. So we are trying to help you navigate whatever your current set of circumstances are on an annual basis.

Mrs. Blackburn. Well, and for our constituents who now realize the cuts that Obamacare made to Medicare and how it affects their hospital and their access and the reduced rate that is going back, reimbursement rate going back to those hospitals, it is a very tangible -- very tangible consequence of the implementation of this law.

And for seniors who have paid into the Medicare trust fund, this is not working well. So it is going to be worthy of a revisit, because that money is in the trust fund and it is now being used for new programs, not for programs that benefit seniors.

I yield back.

Mr. Pitts. The chair thanks the gentlelady.

That concludes our round of questions. The Members will have follow-up questions in writing. We will submit those to you, Dr. Miller, and ask that you please respond to those promptly.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. Thank you very much for your informative exchange.

While the staff sets up for the next panel, the subcommittee will take a 3-minute recess.

[Recess.]

Mr. Pitts. The subcommittee will reconvene.

And on our second panel today we have Mr. Chris Holt, director of healthcare policy, American Action Forum -- welcome; Mr. Marc Goldwein, senior policy director, the Committee for a Responsible Federal Budget; and Dr. Judy Feder, professor of public policy, Georgetown Public Policy Institute.

Thank you all for coming. Your written testimony will be made a part of the record. You will each have 5 minutes to summarize your testimony.

And, Mr. Holt, we will start with you. You are recognized for 5 minutes to summarize.

**STATEMENTS OF CHRISTOPHER HOLT, DIRECTOR OF HEALTHCARE POLICY, AMERICAN ACTION FORUM; MARC GOLDWEIN, SENIOR POLICY DIRECTOR, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET; AND JUDY FEDER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN PUBLIC POLICY INSTITUTE**

**STATEMENT OF CHRISTOPHER HOLT**

Mr. Holt. Thank you, Mr. Chairman, members of the committee. It is certainly an honor to be asked to testify before Congress but particularly for me this subcommittee. With my past work with Representative Murphy and with the committee, having had the opportunity to work with many of you and to come to understand the dedication that you and your staff bring to the important issues that this committee deals with makes this a very humbling opportunity for me, and so I thank you very much for that.

My written statement details some modeling that we have done on Affordable Care Act provisions that -- spending provisions that we could dial up or dial down in order to generate some savings. That modeling I am happy to go into if people have questions. I think that those savings could be used to pay for other spending priorities. But I was hoping to take a step back and maybe talk a little more broadly today about the topic that we are here to discuss.

When I arrived in D.C. 10 years ago as a congressional intern, we had a Federal debt of about $7 trillion. As we all know, today the Federal debt is now past $18 trillion.

We can point fingers and try and lay blame, but the reality is that this is not entirely the fault of one party or the other; we have gotten here together. And I think you can see that if you look at the immediate last two Presidencies. During the Presidency of George W. Bush, we saw the national debt double, and under this Presidency of Barack Obama, we are flirting with doing that again.

So we can argue about whether or not we have a spending problem or a revenue problem, but I hope that we can agree that we have a debt problem.

And while we all have, I am sure, our pet peeves for what is driving that debt accumulation, the 800-pound gorilla in the Federal budget is mandatory spending, which makes up 60 percent of the Federal budget, and, in particular, mandatory spending on health programs, which is about 30 percent of all Federal spending. As this spending continues to grow, it is crowding out discretionary spending, things like defense but also things like funding the NIH.

And so, as we look at that, unfortunately, rather than addressing that looming entitlement crisis, President Obama chose to focus on passing the Affordable Care Act. In doing so, he expanded spending in the Medicaid program and put more people into that broken program.

He also created an entirely new entitlement, these subsidies for the under-65 population available through the health insurance marketplace, and then, all the while, largely ignoring Medicare beyond the $700 billion in cuts that were used to pay for the other priorities, particularly cuts to Medicare Advantage and also to home health.

As we look to the 114th Congress, I think we can recognize that the big policy agenda items that conservatives seek -- repealing and replacing the Affordable Care Act, large-scale Medicare and Medicaid reform -- are likely out of reach, but we can and should take the opportunities that present themselves to move towards those goals.

And so, in particular, as Congress looks at the entitlement spending, both new and old, that continues to grow, I would remind you that the Budget Control Act has largely left the ACA unscathed. And, as such, I think it is appropriate that, as Congress looks to fund other health priorities, particularly the SGR reform that is coming up, that we can look to the ACA as a mechanism by which those other priorities can be paid for.

And then, finally, briefly, I would say, with an eye towards long-term fiscal priorities, I urge Congress to protect the Medicare Part D and the Medicare Advantage programs. These are excellent blueprints for how entitlements could be structured and should be structured, and they provide a roadmap for moving past the fee-for-service Medicare system today.

And, with that, I am happy to take your questions.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Holt follows:]

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Mr. Pitts. Now recognize Mr. Goldwein, 5 minutes for an opening statement.

**STATEMENT OF MARC GOLDWEIN**

Mr. Goldwein. Thank you, Chairman Pitts, Ranking Member Pallone, and other distinguished members of the committee, for inviting me to testify on this important issue.

I would like to focus my remarks this morning on two subjects. First, I would like to make the case for the importance of continuing to focus on slowing Federal healthcare cost growth. And, second, I would like to discuss the policies which I believe have the best chance of making healthcare spending both more effective and more affordable.

I have spent the bulk of my career working with bipartisan efforts to put the debt on a more sustainable path. I worked on the staff of the Simpson-Bowles Fiscal Commission, the Hensarling-Murray Supercommittee, and with a number of Hill offices on an informal basis. Every one of those efforts to stabilize the debt has put identifying reforms to slow the growth of health spending front and center as the central issue.

Unfortunately, the combination of the recent fall in the short-term deficit and the tremendous slowdown in healthcare cost growth has led some to conclude that Medicare and Medicaid reforms are

no longer necessary. In my view, this couldn't be further from the truth, especially considering our debt levels are currently at record highs only seen around World War II and are continuing to grow unsustainably if you look into the future. The slowdown in Medicare and in health spending more broadly is hugely encouraging but, for a variety of reasons, should not be used as an excuse to stop reforms.

My written testimony explains this in more detail, but, first of all, a large share of the recent slowdown is due to temporary factors. These include economic and demographic factors, one-time legislative cuts like sequestration, and other temporary events like the recent prescription drug patent cliff that we are sort of falling off right now.

Secondly, the portion of the slowdown which is structural and permanent, some of it is probably because providers expect future changes in fee-for-service, which means, without further congressional action, they will revert and we will lose the gains we have made so far in the slowdown.

Third, slowing healthcare cost growth will not be enough to keep Federal health spending itself under control. The reason is that the primary driver of Federal health spending over the next quarter-century is not actually healthcare cost growth but it is population aging. As a result, the Congressional Budget Office projects that healthcare spending as a share of GDP, Federal healthcare spending, will more than

double by the early 2050s, possibly sooner.

And, finally, Congress and the President will have to identify health savings early next year in order to offset either a temporary doc fix or, preferably, a permanent SGR fix -- a permanent SGR reform. After all, we have offset 98 percent of doc fixes in the past and, as a result, generated $165 billion worth of savings, mostly from within the healthcare system.

Now, as Congress does look for savings, there are a number of policies which have the potential for broad bipartisan support. At CRFB, my organization, we like to categorize these savings as benders, savers, or structural reforms. And my advice to this subcommittee is to focus first and foremost on the cost benders, those policies which will structurally change the incentives within Medicare and Medicaid in order to slow the growth of healthcare spending overall, not just shift who bears the burden.

Now, these benders can't offer a free lunch. They can't offer a situation where everybody is better off. But what they can do is offer a discounted lunch, where as a society we are better off and where the winners far outweigh the losers.

CRFB, my organization, the Committee for a Responsible Federal Budget, recently released a plan we call the Prep Plan, which identified a number of these benders and used them to pay for the very thoughtful SGR reform that came out of this committee, along with Ways and Means

and Finance.

On the beneficiary side, we included reforms very similar to the MedPAC recommendation. And I want to emphasize that if you modernize Medicare cost-sharing, you can save money for both the taxpayer and the beneficiary. Our plan would save $80 billion over 10 years for the Federal budget and reduce beneficiaries' out-of-pocket costs by about $200 per person per year.

Our plan also looks to change the incentives on the provider side, including by moving to more bundled payments, increasing penalties for unnecessary hospital readmissions, encouraging doctors to administer lower-cost prescription drugs, and rewarding States that move to more efficient payment models within Medicaid.

In addition to these and other benders, which, again, are in my written testimony, you are going to have to look at what we call savers. Now, these are policies where we will save money for the Federal Government by allocating it in a way that is preferable.

There are already a number of these savers that have bipartisan support: increased means testing for Medicare premiums, reductions to certain overpayments to providers, and clamping down on certain scams or certain games played by States in order to increase their Medicaid matches.

You are going to have to look at all of these policies carefully, along with others outside of the health arena, if we truly are to get

our health system and our debt under control. There is no magic bullet, but there is an opportunity to work together on a bipartisan basis and begin making reforms now to give us a better healthcare system at a better price.

Thank you for allowing me to testify on this important topic, and I look forward to working with all of you and your staffs.

Mr. Pitts. Thank you.

[The prepared statement of Mr. Goldwein follows:]

******** INSERT 2-2 ********

Mr. Pitts. Dr. Feder, you are recognized for 5 minutes for your summary.

**STATEMENT OF JUDY FEDER**

Ms. Feder. Chairman Pitts, Ranking Member Pallone, and members of the committee, I appreciate the invitation to appear before you today to express my own and my colleague Paul Van de Water's views on setting fiscal priorities and the importance of preserving Medicare and Medicaid.

I want to make five quick points.

First is that Medicare and Medicaid work. They provide essential health and financial wellbeing to people who are elderly, disabled, or poor. Over more than 40 years, Medicare spending per enrollee has grown by an average of 1 percentage point less than comparable private health insurance premiums. Medicaid provides acute healthcare coverage at a substantially lower cost per child and per non-elderly adult than private coverage. And Medicaid is also the Nation's primary payer for long-term services and support, a matter I know is of concern to Mr. Pallone and others.

Second, Medicare and Medicaid are not in crisis. On the contrary, Medicare spending has recently been growing at a historically low rate, with spending per beneficiary growing more slowly than GDP

per capita.

The financial outlook for Medicare and Medicaid has improved significantly in the past 4 years. Congressional Budget Office estimates of Medicare and Medicaid spending for the next decade have fallen by several hundred billions of dollars since CBO first estimated the impact of the ACA. And Medicare spending per beneficiary in 2014 is expected to be $1,200 lower than CBO projected in 2010.

Third, as Mr. Goldwein said, it is not growth in spending per beneficiary but it is growth in the number of beneficiaries that have become the primary drivers of increased Medicare and Medicaid spending. Even if cost growth remains moderate, Medicare and Medicaid spending will keep rising as more baby boomers become eligible for benefits. And I should note, with candor, I am one. As boomers age, as we age, States will also face considerable increase in the need for long-term care.

Does that mean that we can relax in our efforts to slow cost growth? Of course not. But the focus should be on payment and delivery reform and not capped Federal contributions.

In Medicaid, there is little room for savings from efficiency, given already constrained provider payment rates, widespread use of managed care, and existing opportunities for State flexibility.

RPTS ZAMORA

DCMN HUMKE

[12:33 p.m.]

Ms. Feder. Most proposals that would secure more than modest Federal savings, such as a block grant or a per capita cap, would do so by shifting costs to states, and if that occurs, states are likely to cut eligibility, benefits or provider payments, enhanced reduced beneficiaries access to care. But Medicare policymakers cannot only use the ACA, encourage research and pilots to continue to gain value for the dollar, but can further reduce spending without jeopardizing quality or access to care.

Restoring the Medicaid rebate on prescription drugs for low-income beneficiaries, eliminating overpayments, continued overpayments to Medicare Advantage plans, and refining payments mechanisms for post-acute care are a few examples of policies likely to increase value for the Medicare dollar.

Only so much can be expected, however, of reducing Medicare costs per beneficiary if that is done independent of lower cost growth and the system as a whole. New revenues are therefore needed to deal with a doubling of the elderly population over the coming decades.

My fourth point: What current circumstances do mean is that claims of cost growth or fiscal crisis cannot be used to justify moves

to radically reform Medicare and Medicaid. There is no question that premium support or other mechanisms that would change Medicare from a defined benefit to a defined contribution program would raise the fundamental concern of a cost shift from the Federal Government to beneficiaries.

The same is true for the block grant or per capita cap, as I mentioned earlier, and that is because these mechanisms would sever the tie between Federal contributions and the beneficiary's costs. The more constrained the defined contribution or the cap, the greater the shift. Premiums support vouchers, block grants per capita caps or overly ambitious spending targets might save Federal dollars but they shift risks on beneficiaries who can ill afford to pay them.

My final point is to urge you to recognize that the deficit has stabilized as a share of GDP, that healthcare spending is growing at historically low rates. That is good news, and it gives policymakers time to identify further steps that when we needed to slow the growth of healthcare costs throughout the entire U.S. healthcare system without impairing the quality of care so that we can meet our responsibilities to an ageing population just as we did in education when the very same individuals entered public school about 60 years ago.

The Nation's fiscal capacity does not provide an excuse to abdicate those responsibilities by radically restructuring Medicare,

by replacing Medicare's guaranteed coverage with a premium support voucher, or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

Thank you.

Mr. Pitts. Chair thanks the gentlelady.

[The statement of Ms. Feder follows:]

******** INSERT 3-1 ********

Mr. Pitts. I will begin the questioning. Recognize myself 5 minutes for that purpose.

Mr. Goldwein, today Medicaid is the largest health insurance program in the world, covering more than 70 million people in 2013. Spending for this program is set to double in the next 10 years and the program already consumes $1 of every $4. We have heard repeatedly from our colleagues on the other side of the aisle that Medicaid is off the table when it comes to considering any policy that would reduce Federal spending. Do you think this is appropriate or sustainable? And please elaborate.

Mr. Goldwein. I don't think that you can afford to take any program off the table when it comes to healthcare cost growth. That said, Medicare is much easier for the Federal Government to address because we control the levers. We know how to -- Medicaid is a joint program with the states, and so I think the best thing we can do for now is empower the states to find new types of ways to save money, to have better payment systems.

There are certain places we can impose those savings. There is borderline fraud, it is not quite fraud, but there are games that states play we should clamp down on. But really, I think the best thing we can do is give the states more freedom and more power to experiment with new cost control ideas.

Mr. Pitts. Mr. Holt, the HHS Inspector General, GAO, and a broad

coalition of stakeholders have identified structural and systemic concerns with the 340B programs. Research suggests the programs discounts may be going to hospitals that do not disproportionately serve Medicaid or the uninsured. Other analysis suggests that the discounts are not passed on to the low-income individuals for whom the program was designed.

Given these concerns, and with more people enrolled in health coverage through the ACA, isn't it time for complete revaluation of the 340B program; and, also, if the 340B program was more targeted, would that free up more drug industry dollars for additional research and development and life-saving cures and life-enhancing therapies?

Mr. Holt. So yes and yes.

First, let me plug, we have a very good primer on the 340B program and the American action forum that I am happy to share with anyone who would be interested in. I think it is important to remember this program exists largely because of Federal meddling and what was already going on in the first place. Originally, the pharmaceutical companies were providing some discounts to some of these hospitals, and as we started getting into things with ASP, they started rolling back those deals because it was impacting what they could sell in Medicaid for.

Today, though, we have got hospitals like Johns Hopkins which benefit from the 340B program dramatically because of the locality that they are in, not necessarily their financial standing. I absolutely

think that in a post-ACA world we must look at all of these programs that were intended to subsidize uncompensated or undercompensated care, and we have to reevaluate all of that.

Mr. Pitts. Please provide us with a primer. We will circulate to the members.

Mr. Holt. Absolutely.

Mr. Pitts. Dr. Feder, the President's fiscal year 2015 budget endorses a policy of further increasing an income-adjusted Medicare premium until capping the highest tier at 90 percent. As the President said in that budget, quote, "This proposal would help improve the financial stability of the Medicare program by reducing the Federal subsidy of Medicare cost for those who need the subsidy the least."

Do you believe this would be a viable offset for paying for the SGR package?

Ms. Feder. No, sir, I don't. I believe that the President put forth those proposals in the context of discussing broader budget agreements that would involve tax increases as well as spending reductions and in the context of looking for a balanced approach to reducing the deficit.

Standing on its own and using Medicare beneficiaries as a piggy bank does not make sense to me. Medicare beneficiaries, half of them, as was said earlier, live on incomes that are below $26,000, including their spouse's income.

We do not have a tremendously large, wealthy, elderly population, and I am concerned that efforts to further means test the premiums can erode the universality of the program, which is one of Medicare's greatest strengths.

Mr. Pitts. According to the Social Security Administration records, there are 60,000 seniors with Medicare who have annual incomes in excess of $1 million. Do you believe it is appropriate we charge them more?

Ms. Feder. Well, Chairman Pitts, those beneficiaries have paid payroll taxes into the system for Medicare on their entire earnings, although the $1 million may not all come from wages, but they have been paying them from wages and now they do pay them also on overall earnings. So people are paying into the system regardless of the income, and we already do have some income relationship with our premiums. That, to me, is legitimate.

I would also say that in terms of your earlier question of using this to pay for the SGR, that in my testimony I have offered you other mechanisms for savings in terms of refining payment rates in Medicare, and I believe that you heard some from Mark Miller that MedPAC has offered, which I think might be far preferable if you are looking for offsets.

Mr. Pitts. But you do not believe it is appropriate to charge them more?

Ms. Feder. They are charged more.

Mr. Pitts. The million dollar?

Ms. Feder. They are charged more.

Mr. Pitts. My time has expired.

The chair recognizes the ranking member 5 minutes for questions.

Mr. Pallone. Mr. Chairman, I would ask unanimous consent to submit for the record an issue briefed by the Leadership Council of Aging Organizations on MedPAC's extra help copayment proposals.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pallone. Thank you, Mr. Chairman.

My questions are to you, Dr. Feder. I was troubled by the policy proposals in the testimony of both Mr. Holt and Mr. Goldwein that seemed to devalue the Medicaid program. And by rolling back the Federal contribution to State Medicaid programs and shifting greater costs onto State budgets, access to care for those may be seriously hindered as State's restrict enrollment due to budget shortfalls.

So my first question is, so what would be the result of rolling back the Federal contribution to State and Medicaid programs?

Ms. Feder. Well, Mr. Pallone, we also, as you well know, we already see that states are constraining some of their services based on their decisions about what they can afford and are willing to spend, particularly in the area of long-term care services for either elderly people or people with disabilities. We know that there are long waiting lists for home care, for example, which is a tremendous matter of concern.

We also know that Medicaid, one of its greatest values is to be able to have the funding respond as needs arise. So in the Great Recession, we found that Medicaid responded to the growing need of the population, that we had so many low-income people. We see Medicaid similarly respond when new drugs come on line that are expensive but can make a real difference to people's ability to get care they need.

So we have lots of experience on which we can draw and lots of

research shows that an arbitrary constraint in terms of the Federal share, what the Feds are contributing to Medicaid costs will have an impact on the programs, absolutely, but that impact will fall on providers. They will get less payment. They have been on beneficiaries who will get less access to service, and that the program would be diminished as a result.

Mr. Pallone. I appreciate you bringing up long-term care too, because I think a lot of times some of us forget the link between Medicaid and long-term care nursing home care, which I think is another issue that, you know, we really should be addressing --

Ms. Feder. Absolutely.

Mr. Pallone. -- in a significant way, you know, what we are going to do about long-term care. But many governors, even Republican ones, even mine have opted to participate in the Medicaid expansion offered as part of the ACA because it is good for their states and good for their citizens.

Moreover, there is empirical evidence showing that Medicaid improves health. For instance, the 2008 Oregon study that expanded Medicaid coverage had substantively and statistically hired utilization of preventive and primary care, lower out-of-pocket medical expenses and lower medical debt and better physical and mental health.

So my second question is, it would appear that there is actual

empirical evidence to refute a devaluation of the program and that Medicaid coverage not only helps improve health but keeps people out of medical debt.

Do you want to comment on the benefits of the Medicaid program in that respect?

Ms. Feder. I agree with you 100 percent that the value of Medicaid to individuals who would, without it go without coverage, has been demonstrated many times over. The evidence you cite is recent evidence that researchers like because it is not influenced by the differences in the population, the more-likely-to-be-sick population that is in Medicaid versus the other populations. And this evidence is particularly confirming of Medicaid's value, although it too had some issues in not fully capturing it.

So Medicaid on the health side for families and kids and on the long-term services and supports for people who are elderly or disabled is extraordinarily valued and we prove it all the time.

Mr. Pallone. All right. I am going to try to get quickly to this last thing. House Budget Committee Chairman Paul Ryan has continued to propose to convert Medicare into a voucher system for the purchase of private health insurance, and the Urban Institute analysis show this would result in a fairly dramatic shifting of cost to beneficiaries.

What is your analysis of this Ryan proposal, and what are the dangers to Medicare and their beneficiaries from such a proposal?

Ms. Feder. Well, I share with my colleagues at the Urban Institute precisely that concern, that it is a shift of cost to beneficiaries rather than a savings in cost. We know from experience, we have seen some advocacy lately that competition is working in Medicare Advantage plans, that we can see that risk selection is no longer a problem, but those are claims that are not supported by the evidence.

MedPAC demonstrates that when you have competing plans there is, even as we refine our ability to adjust payments to plans for differences in risk, that the risk selection occurs, that healthier people are served by the plans and sicker ones are avoided or end up disenrolling. And we see, as Mark Miller said earlier, that -- a decided risk that we will lose our capacity to contain costs which Medicare has been so effective, relative to the private sector and to private plans.

Mr. Pallone. Thank you.

Thank you, Mr. Chairman.

Mr. Pitts. Chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questioning.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it very much.

Mr. Goldwein, in your testimony, you talk about budget choices and you classify some of the options as benders or savers. I have been

concerned about the prescription drug abuse within the Medicare part D program and overall program integrity.

Would establishing a safe pharmacy network to provide a single point of self or at-risk beneficiaries and providing part D plans additional authority against fraud be bender or a saver? Would this save the Government and taxpayers, again, real money?

Mr. Goldwein. So establishing a safe pharmacy, I think, would save money. I can't quantify how much, and I have not seen a CBO score on it. But by clamping down on basically abuse of prescription drugs and overmedication, it will certainly save Medicare money.

I also think this would categorize as a bender because this is one of those wins-wins, where not only would Medicare be better off, but the beneficiary that potentially could become addicted to the drug is better off and society is as well. So it is definitely something worth looking at.

Mr. Bilirakis. Thank you.

And next question for Mr. Holt. Private health insurance was the model used to build the Medicare part D program. Congress used what was successful in the commercial sector and brought that success into Medicare. Shouldn't we use the innovation and tools in the private sector to address some of the drug abuse and fraudulent billing practices in Medicare part D?

Mr. Holt. Yeah, absolutely, and we already use similar programs

in, I think, about 46 of the State Medicaid programs. So, and I think this is an excellent idea. I know both HHS and CMS have said that they support it. I think the committee largely is supportive of this policy, and I think if you can get some savings on top of just good policy, I think that is an excellent choice and move in that direction.

Mr. Bilirakis. Thank you very much.

I yield back, Mr. Chairman.

Mr. Pitts. Chair thanks the gentleman.

Now recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Thank our panel for being here. As we have seen since the passage of the Affordable Care Act, industry stakeholders have continued to make claims that cuts to Medicare Advantage program would lead to reductions in benefits and increased premiums, but the exact opposite has occurred over that period of time. In fact, premiums have dropped 10 percent and enrollment has increased nearly 30 percent since the ACA required plans to be more efficient in their delivery.

Mr. Goldwein, in your testimony you propose one of your saver policies to increase the coding intensity adjustment to reclaim additional overpayments to Medicare Advantage plans. Could you describe this policy and your rationale behind it?

Mr. Goldwein. Sure. Well, let me first say that the policies

I listed in my testimony, other than those which were in our prep plan, are not my recommendations but just a list of options.

Now, the President has proposed coding intensity adjustments for Medicare Advantage, which essentially would recoup money that shouldn't have been paid to these plans in the first place, because in some cases, they are over-coding activities, coding them at something that is more expensive than they otherwise would be.

What the exact coding adjustments should be year to year, I can't tell you. I think MedPAC could probably tell you better. But this is the President's recommendation, and certainly we should be continuing to make sure that Medicare Advantage is spending its money as efficiently as possible.

Mr. Green. Okay. Even today you heard Mr. Holt's testimony how payment reductions in Medicare Advantage plans would lead to reduce benefits for enrolling in 2015. I believe the plans were well suited to observe these cuts by becoming more efficient without harming beneficiaries, as MedPAC has indicated.

Dr. Feder, one concern I have is that in 2014 planned payments on an average of 106 percent of fee-for-service, if plans cannot compete at fee-for-service rates, do they really belong in the program? We are paying them more and there is no more concrete evidence their quality is better. Shouldn't we require better from plans as in more efficient performance and better quality if they are to remain part

of Medicare?

Ms. Feder. I agree with that approach, Mr. Green, and with your point that we continue to overpay Medicare Advantage plans relative to payments in the traditional program. I don't see any reason for that and have written and argue that payments should not be higher than what we pay in the traditional plan on the per-capita basis.

Mr. Green. Well, and that is one of my concerns. I was here when we created Medicare Advantage and it was supposed to save Medicare funding not cost many more. And I know I have constituents, about 25 percent of my Medicare folks get Medicare Advantage, but when I explain to them you are actually costing more for Medicare than the 75 percent that is not, you know, then they think about it and say, oh, okay, they didn't know that.

But, Dr. Feder, does it seem irresponsible for us to spend taxpayer and beneficiary money to prop up private industry that benefits only a third, at best, at the expense of the other 70 percent under traditional Medicare?

Ms. Feder. It does not, and although we have made, I think, the reforms, and Mark Miller laid them out on the previous panel, that have been made in payments to MA plans and through the ACA have reduced those overpayments and are making strides, I think it is not appropriate to over-subsidize those plans.

Mr. Green. Okay. The title of today's hearing, Doctor, is

"Setting Fiscal Priorities," and it appears to solve an economy against spending on entitlement programs for those Americans with the greatest need. It seems that term "entitlement" has come to mean different things to different people. Too often people think of entitlements through the narrow lens of programs to provide the safety net for our seniors and the most vulnerable in our society by considering the fiscal impact of the tax entitlements, tax deductions, exclusions, credits, and other tax preferences, which disproportionately benefit well-to-do Americans.

Can you talk about entitlements, both those providing essential services to seniors and low-income Americans and those providing tax break to the more affluent and the relative role of each in the context of protecting the most vulnerable in our society in addressing our long-term debt?

And I know that is a long question for the last 30 seconds.

Ms. Feder. I will try and go fast. The entitlements that you speak of, I think, are colloquially defined inappropriately. They accurately mean benefits to which citizens have a right enforceable in court, and that they are typically mandatory spending programs so that the money flows with the population who is eligible for the program and the costs of the benefits that are provided.

You are quite correct that they are provided through the tax system as well as in direct spending, even when they are social service

benefits. So the tax benefits that we receive on mortgages, on pension plans, on employer-sponsored health insurance, are all entitlements that essentially go to the upper end of the income distribution.

And a substantial, the bulk of those benefits do go to the better off, and by virtue of their structure, with the exception of benefits that are refundable tax credits like the EITC, they do not go to low-income people. So the tax benefits are skewed up the income scale, and I am talking about the good, the social service type benefits. There are others that are really skewed up the income scale.

By contrast, it is the low and modest income population who benefits appropriately and probably disproportionately from the benefits that are provided by Medicare and Medicaid and benefits like that, that come through Social Security, that come through direct payment.

Mr. Green. Thank you, Mr. Chairman. I know we are over time and appreciate your courtesies.

Thank the panel.

Mr. Pitts. Chair thanks the gentleman.

Now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Thank you, Mr. Chairman.

And Congressman Green, I was glad you got back into the Medicare questions involving the Affordable Care Act because there have been,

people have kind of played fast and loose with some of the statements today by continuing to imply that the Affordable Care Act cut Medicare, and you are implying to the Medicare beneficiaries our older neighbors, our parents and grandparents, that they have suffered, their benefits have been cut, which could not be further from the truth.

Under the Affordable Care Act reforms, Medicare benefits are better. Remember the donut hole is closing so you have more money in your pocket when it comes to paying for your prescription drugs. You get that free wellness visit every year. You get the important visit for your mammogram or colonoscopy or cholesterol check without a copay. Benefits have gotten stronger; isn't that right, Dr. Feder?

Ms. Feder. Absolutely.

Ms. Castor. And meanwhile, what we focused on the Affordable Care Act is cutting the waste in the overpayments to health insurance companies that Dr. Miller, the MedPAC expert, testified to. This is smart policy. So let's turn the page on this and get to the fact that we have more work to do with the aging population and the baby boomers retiring. We still have to ensure that Medicare is there for future generations, like Generation X and the Millenials, I hope so.

So let's talk also about Medicaid because I hear these arguments too that Medicaid is not efficient, that this is a huge cost -- yes, it is a big draw on the Federal budget, so we have got to focus on reforms. My colleagues on the other side of the aisle often refer to

the inefficiencies of Medicaid. In fact, Medicaid's costs per beneficiary are substantially lower than per beneficiary costs for private insurance, and Medicaid's cost per beneficiary have been growing more slowly than per beneficiary costs under private insurance. So it appears that Medicaid is more efficient than private insurance, and yet many conservatives say we need to replace Medicaid with a voucher or cap its funding.

And what you are saying there is that our parents and grandparents that relied on skilled nursing and need to go into nursing homes, and with these baby boomers, the policy decision is to take the access to the nursing home away or to children with disabilities that we are not going to be there in a cost-efficient manner to help you survive, I just don't think that is smart policy.

So Dr. Feder, while this might save money, if you block grant or you cut and you slash, how can we expect to really cut healthcare costs while Medicaid is already cheaper than private insurance?

Ms. Feder. Well, I think that your point is well taken and that this is really not a way to save money. It may reduce Federal spending, but it would shift costs to states and in all likelihood, based on past experience, would leave beneficiaries without needed services just as you describe. That is simply not an acceptable way to meet our obligations to our most vulnerable populations, and those demands are only going to grow as the population ages, as more and more people need

not just nursing home care. We are more often now or more often than we were providing care at home, which is where people want to stay, and we need to be able to do that.

To expect Medicaid to do that on some notion that an already lean program can somehow be magically more efficient makes no sense at all. Medicaid can participate and is participating with Medicare in the private sector in improving delivery to minimize and reduce inefficiencies. But in all likelihood, as the population ages, Medicaid needs more support not less.

And I find it -- if you would, for one more moment -- I find it interesting that your colleagues across the aisle want to spend less on Medicaid and pull those Federal dollars back when we know that states are arguing that -- some states are resisting Medicaid expansions because they think the Feds are not going to come through with the needed dollars. So it seems to me that this becomes a wish fulfillment on the part of those who are opposed to adequate coverage.

Ms. Castor. Thank you very much. I yield back.

Mr. Pitts. Thank you.

We will go to one follow-up per side. I will recognize myself 5 minutes for that purpose.

Mr. Holt, the New York Times has a story this morning about a new report from the HHS Office of Inspector General that is being issued today, and the report found, quote, "Half of providers listed as

accepting Medicaid patients could not offer appointments to enrollees," end quote, for non-urgent visits.

Now, the President's health law is fueling rapid growth in Medicaid with enrollment up by 9 million people just this year. The inspector general warned that, quote, "When providers listed as participating in a plan cannot offer appointments, it may create a significant obstacle for an enrollee seeking care," end quote.

According to HHS, the Nation is already going to be 20,400 primary care physicians short by 2020, just a few years from now. Should Congress be concerned that the shortage of doctors and low participation rates in Medicaid along with the Medicaid expansion means that the most vulnerable patients will face worse access problems?

Mr. Holt. Yeah, absolutely. I haven't seen the study yet, since it came out while we were sitting here, I think, but my big concern about the Medicaid expansion has been that you are putting more people into this program. There is already difficulty in Medicaid beneficiaries getting access to doctors. And we have to keep in mind that having coverage is not the same as having access and having access is not the same as having better outcomes.

And so I think it is very important that as we look at the expansion, which sort of disincentivizes the enrolling of lower-income individuals who were previously eligible because they were met at a lower match but pays states quite a bit more, right now 100 percent,

to enroll, higher income, still lower-income individuals that were sort of incentivizing the states to focus on the wrong population, and we are making it harder for those people, the most vulnerable, to get to doctors, to get to care.

Mr. Pitts. Mr. Goldwein, under the Affordable Care Act, states have the option to expand Medicaid to adults with no children, with income under 138 percent of the Federal poverty level. This was an unprecedented expansion of the program that traditionally has covered low-income moms and kids, the elderly, poor, the blind, and disabled. Under the expansion, the Federal Government is paying 100 percent of the cost of the expansion until 2016 when states have to start picking up some of the tab.

Accordingly, under Federal rules today, the Federal Government is paying the full cost of some prisoners' hospital care who would otherwise be eligible for Medicaid, the medical bills of multimillion dollar lottery winners who states are barred from disenrolling in the program. Do you think this is an appropriate use of Medicaid dollars?

Mr. Goldwein. Well, I think, by and large, there was a decision in the Affordable Care Act to use Medicaid rather than the insurance subsidies to cover that population between 100 and 133 or 138 percent of poverty. And that was a reasonable choice where you could have disagreed. Now, within that population, there certainly are going to be some cases where there are beneficiaries that don't really merit

receiving benefits and there probably is an opportunity to look at those on an individual basis and find places where states can cut off those benefits.

Mr. Pitts. Dr. Feder, one of the concerns about Federal spending on entitlement programs is that such spending is crowding out other parts of the Federal budget. For example, this committee has had a strong bipartisan tradition of supporting research and science at the National Institutes of Health. It will be impossible to find increases to the NIH budget without some reforms to our entitlement programs.

Under current law and projections, should Congress be concerned that discretionary portions of our budget like the NIH will face increasing budgetary challenges without some reforms to the mandatory healthcare spending?

Ms. Feder. Well, Chairman Pitts, I would like to reiterate what I believe that Mr. Pallone said a little while ago, which is that the Affordable Care Act was entitlement reform and has generated enormous savings in the Medicare program. And, in fact, if we look at the deficit reduction that has occurred overall in the last several years, about three quarters of it has come from spending reduction, not revenue increases. And as I said earlier, if we expect to meet the demands of our society, we cannot continue to constrain spending whether discretionary spending is getting very hard hit, and I agree with you that it is unacceptable.

But the way to address that is not to create inadequate supports in strong programs; it is to adequately generate revenues to support the needs of our population.

Mr. Pitts. Would you not agree that much of that spending reduction is due to the use of generics?

Ms. Feder. Not the spending -- that is true if you are referring narrowly to some of the spending. Some of the spending reduction in Medicare on part D, for example, lower than was estimated, is due to an expansion of generics in part, but to other factors as well that affected the whole industry was not necessarily a reflection of the part D design, but I am talking more broadly about the budget.

Mr. Pitts. Thank you. My time is expired.

Chair recognizes the ranking member, 5 minutes for questions, follow-up.

Mr. Pallone. Thank you.

In my previous question I said that I believe that simply turning Medicare into a voucher is shortsighted and simply shifts costs onto seniors and people with disabilities, and I believe there are more thoughtful ways to address healthcare costs growth. And you sort of got into this, Dr. Feder, but the Affordable Care Act sets the stage and began to put in place some initiatives to address cost growth without harming patient care.

Could you give me your views on the reforms and the ACA and their

ability to address cost growth?

Ms. Feder. Well, actually, we heard a lot about those in the first panel.

Mr. Pallone. Right.

Ms. Feder. So I think that we are seeing efforts to tie payments more closely to performance, to encourage providers to be more efficient in their delivery of care. Prime example for that is the penalty for readmission rates. I think that that ought to be monitored and done properly, but I think we are seeing positive results there.

The law went beyond that to create a new option in terms of the way in which providers get paid instead of rewarding more for ever more expensive and higher-volume services. We see the creation of the accountable care organizations that rewards providers if they meet performance standards, a very important aspect of it and then labels them to share savings. And we see many pilot programs exploring improved efficiency in the delivery of care in both Medicare and Medicaid.

We see, for example, in the area we talked about earlier, independence at home, which is having doctors serve and people who need long-term care services going to the home. That is an exciting change or benefit to explore. We are seeing health homes where those same individuals get support services, particularly focused on improvements for those who need behavioral health services, which I heard a member

talk about earlier.

And we have a variety of demonstrations of various kinds that are focused on holding providers accountable for the delivery of quality care, rewarding them for that performance rather than for higher-volume services.

Mr. Pallone. Thanks.

And you pointed out that the ACA improved Medicare's financial solvency. It is now projected to be in good standing for an additional 4 years until 2030, according to the Medicare Trustees. Just talk a little bit about the financial health of the Medicare program. What are the fiscal challenges? What kind of timeframe are we looking at in terms of the ability of current Medicare revenues and the Medicare hospital insurance trust fund to continue to cover the cost of the program?

Ms. Feder. Well, as we look, we have to always remember the different ways in which the program is funded and you hear people talk about the exhaustion of funds. That is, as you have correctly said, only about part A, where the funding is generated by predetermined payroll tax rates. Part B and part D are funded through general revenues in large part and to some extent then through beneficiary premiums. So there is no issue of exhaustion of trust funds when it comes to those other programs.

On part A, we know that in Medicare, like as in Social Security,

that we have a growing elderly population dependent on a now smaller working age population. And so when we talk about the exhaustion of the trust fund, when the program will still be able to pay three quarters of its benefits but not all -- I believe that is the number -- we talk about exhaustion of the trust fund, that reflects the fact that looking out that payroll tax revenues that are already -- or payroll tax rates are not expected to generate sufficient revenues to support the program at that time.

But that is, as you say, a long way from now. We have been much closer to that exhaustion date, Congressman, in previous years, Congress has always taken action to assure the soundness of the program. And as I said in my testimony, with us experiencing now the lowest health cost growth in the Nation's history -- anyway since 1960, that is not quite the Nation's history -- it is a time for us to continue to explore the payment reforms and payment refinements, not just in Medicare or in Medicaid but in the entire healthcare system so that we can keep cost growth low and even though we will likely need new revenues for a growing elderly population, with strong economy and efficient healthcare systems, we are absolutely capable of meeting our responsibility.

Mr. Pallone. Thanks so much.

Mr. Pitts. All right. That concludes member's questioning for now. I am sure members will have follow-up questions they will submit

to you in writing those questions. We would ask you to please respond promptly. I remind members they have 10 business days to submit questions for the record and they should submit those questions by the close of business on Tuesday, December 23.

**This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.**

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. Very informative hearing.

Thank you very much. Without objection, this subcommittee is adjourned.

[Whereupon, at 1:12 p.m., the subcommittee was adjourned.]